FIG. 1
(PRIOR ART)

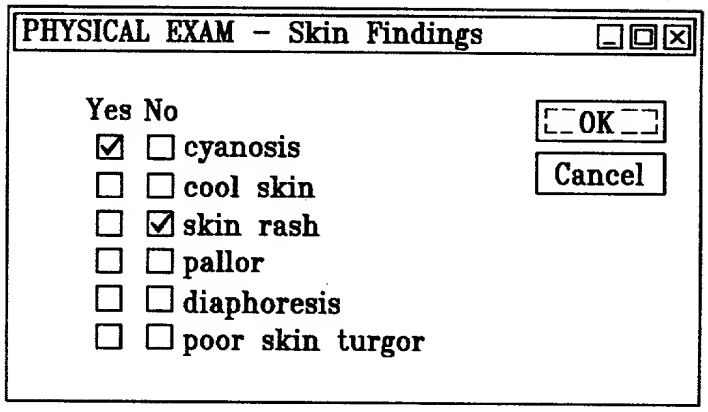


FIG. 2

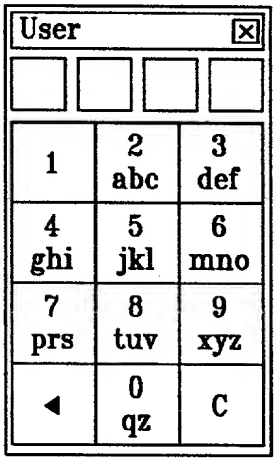


FIG. 3

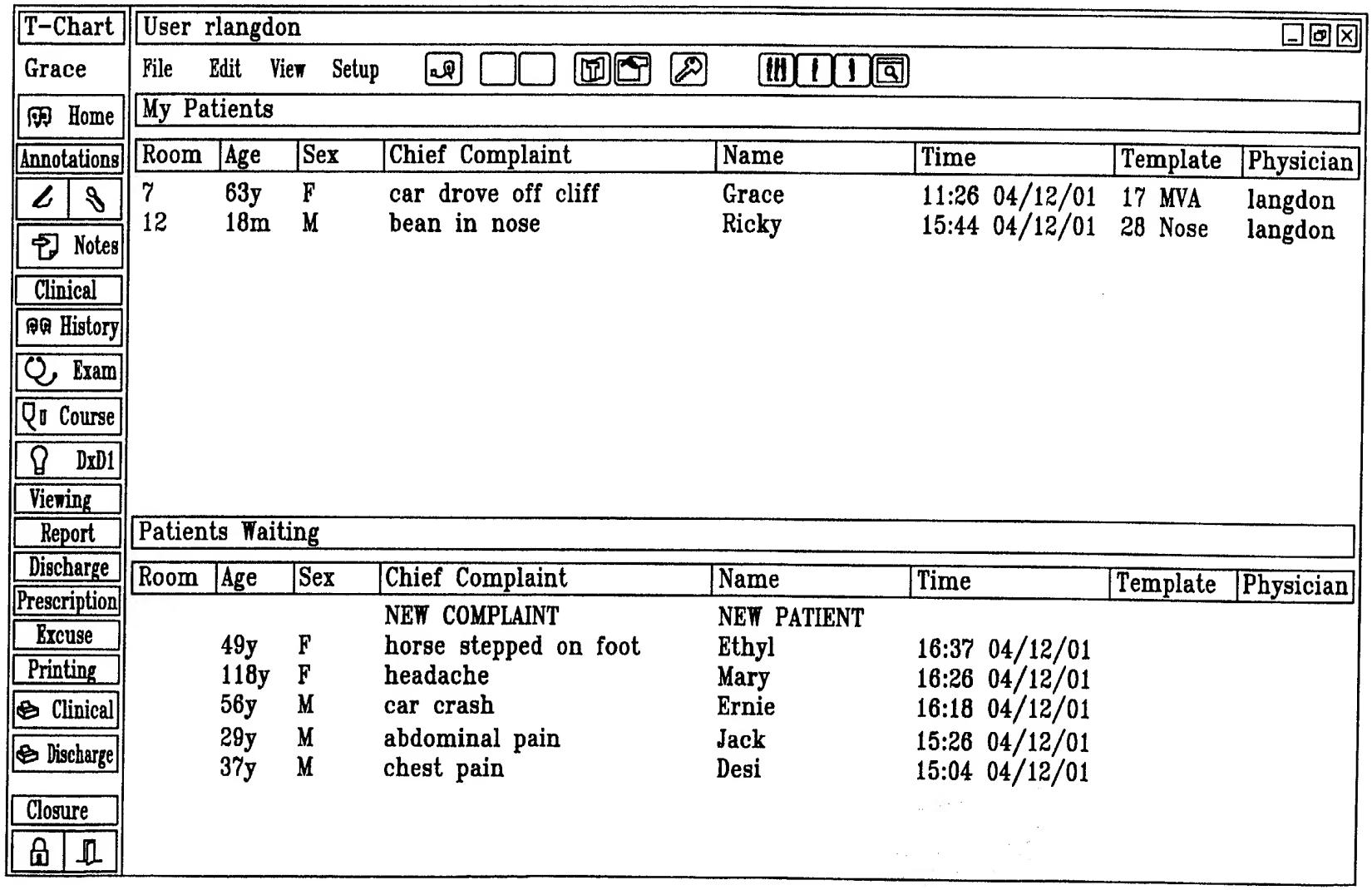


FIG. 4

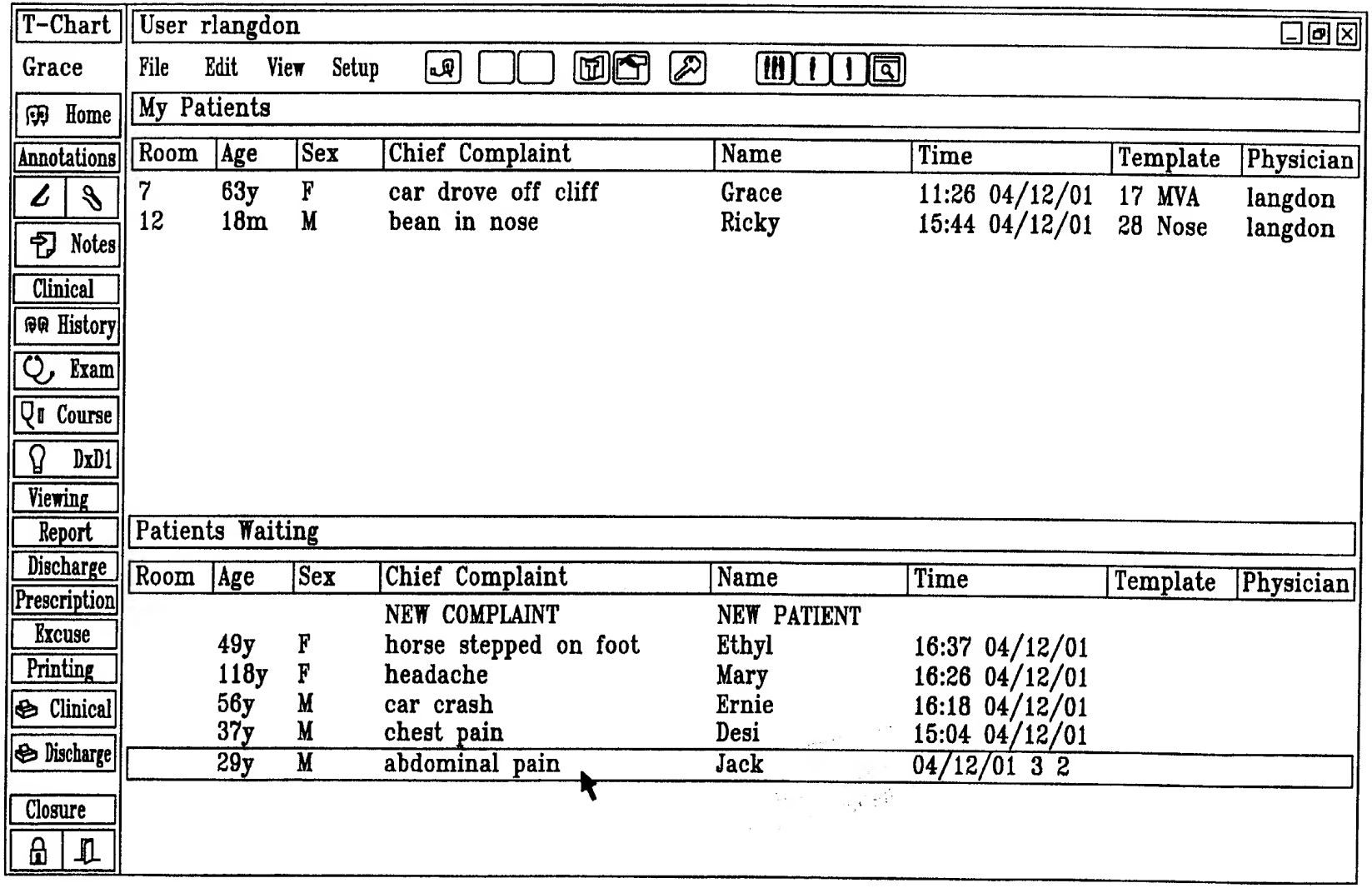

T-Chart
Grace
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
User rlangdon
File Edit View Setup
My Patients
Room Age Sex Chief Complaint Name Time Template Physician
7 63y F car drove off cliff Grace 11:26 04/12/01 17 MVA langdon
12 18m M bean in nose Ricky 15:44 04/12/01 28 Nose langdon
Patients Waiting
Room Age Sex Chief Complaint Name Time Template Physician
NEW COMPLAINT NEW PATIENT
49y F horse stepped on foot Ethyl 16:37 04/12/01
118y F headache Mary 16:26 04/12/01
56y M car crash Ernie 16:18 04/12/01
37y M chest pain Desi 15:04 04/12/01
29y M abdominal pain Jack 04/12/01 3 2

FIG. 5

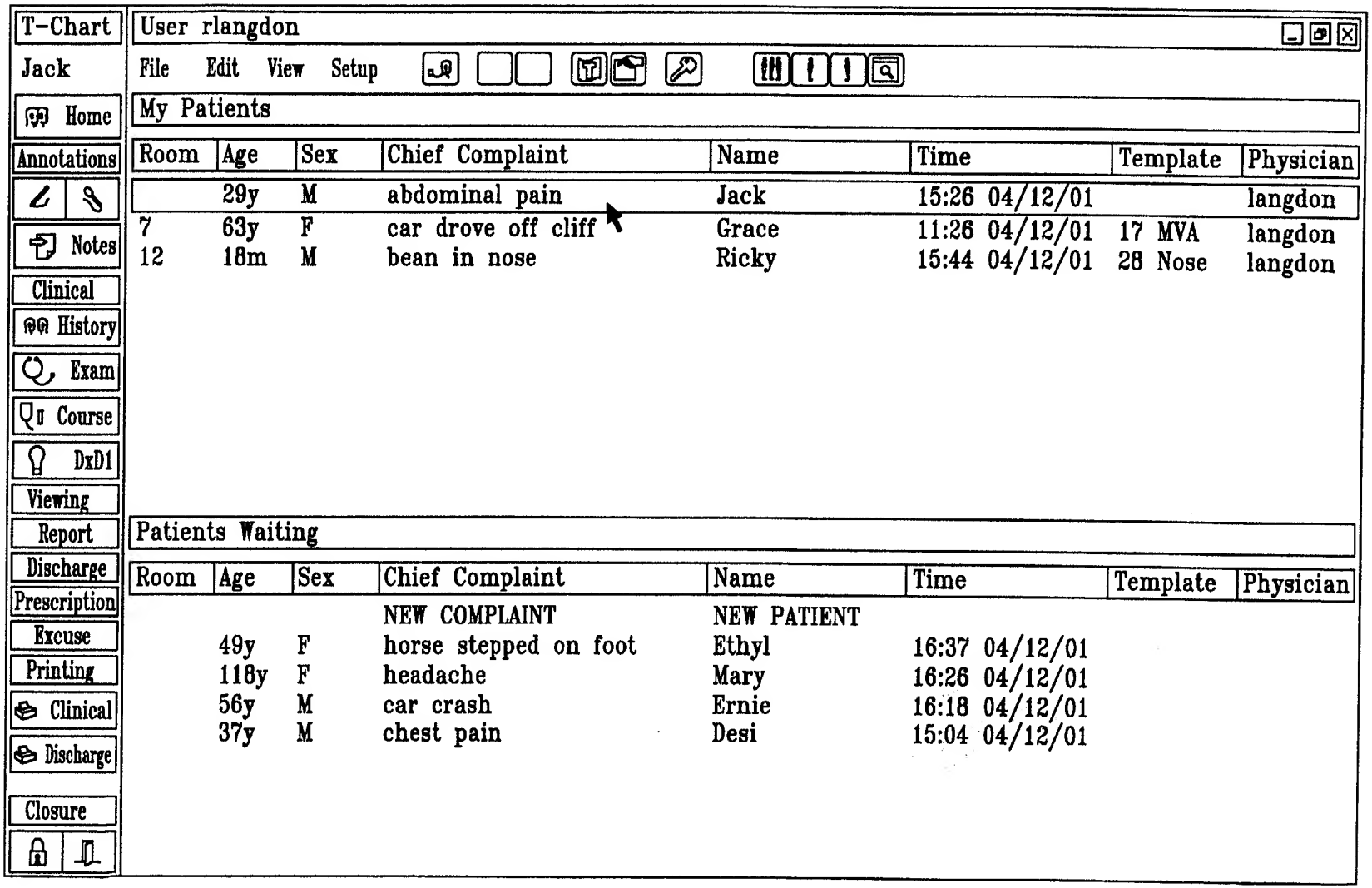


FIG. 6

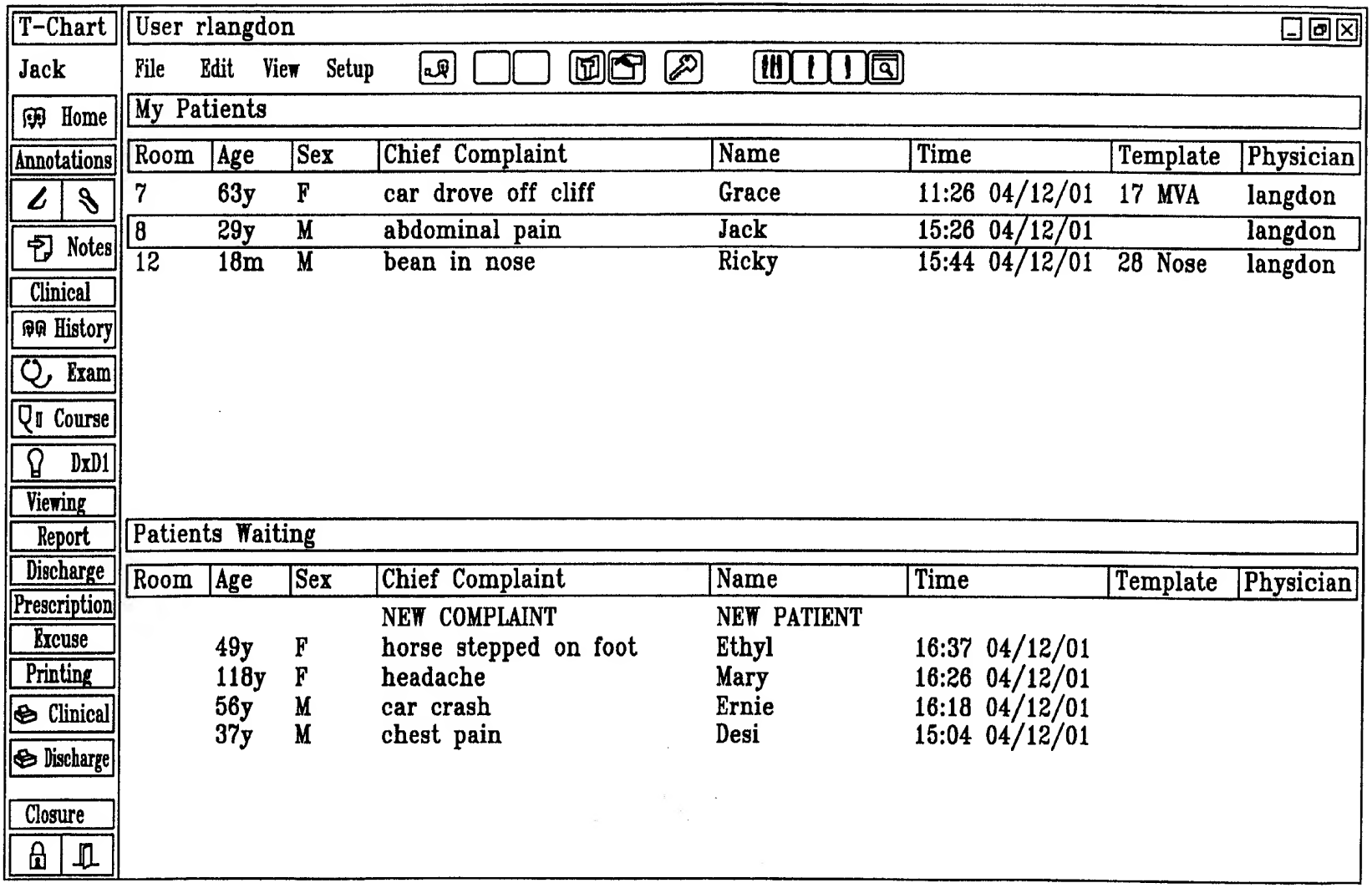


FIG. 7

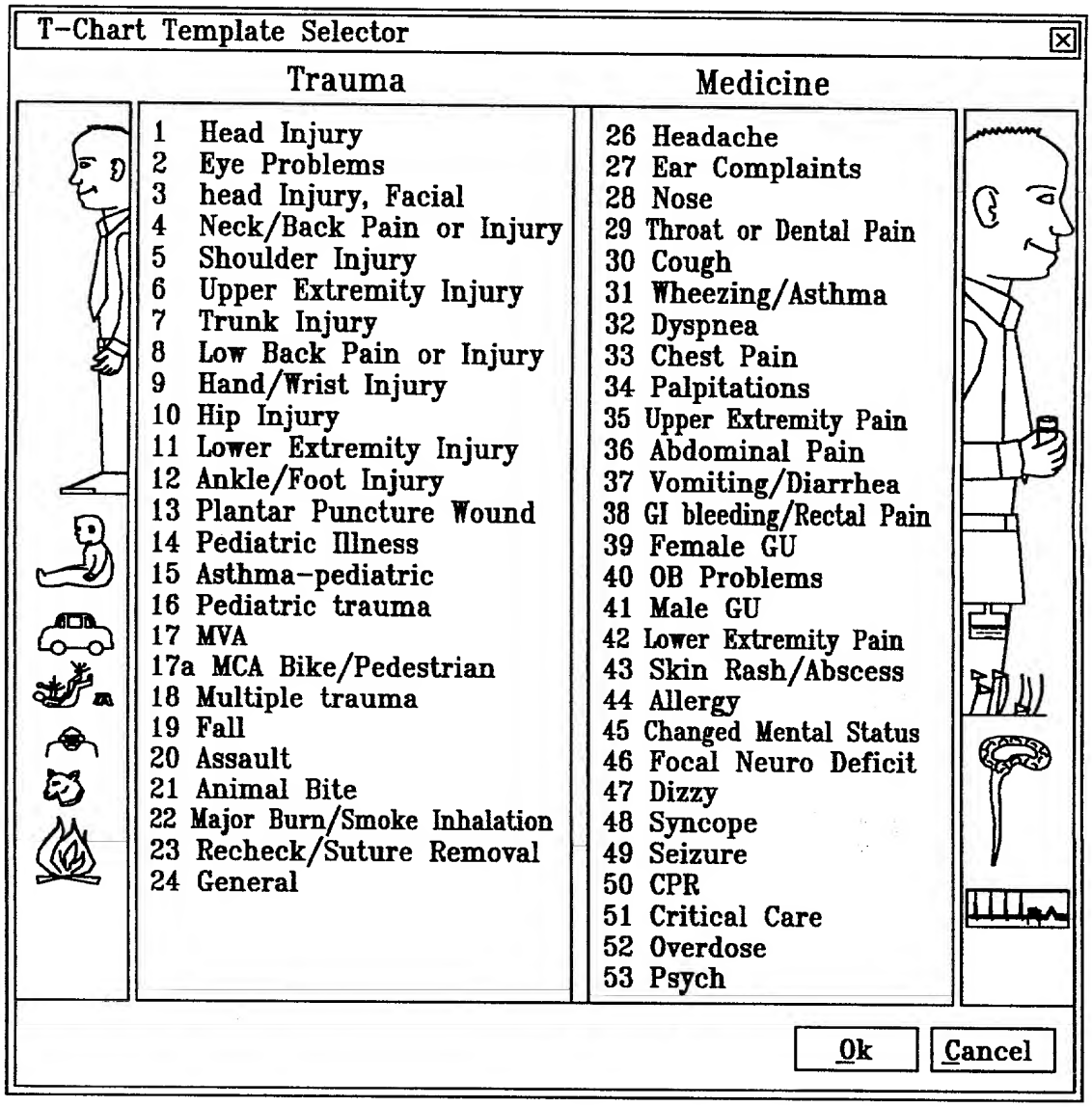
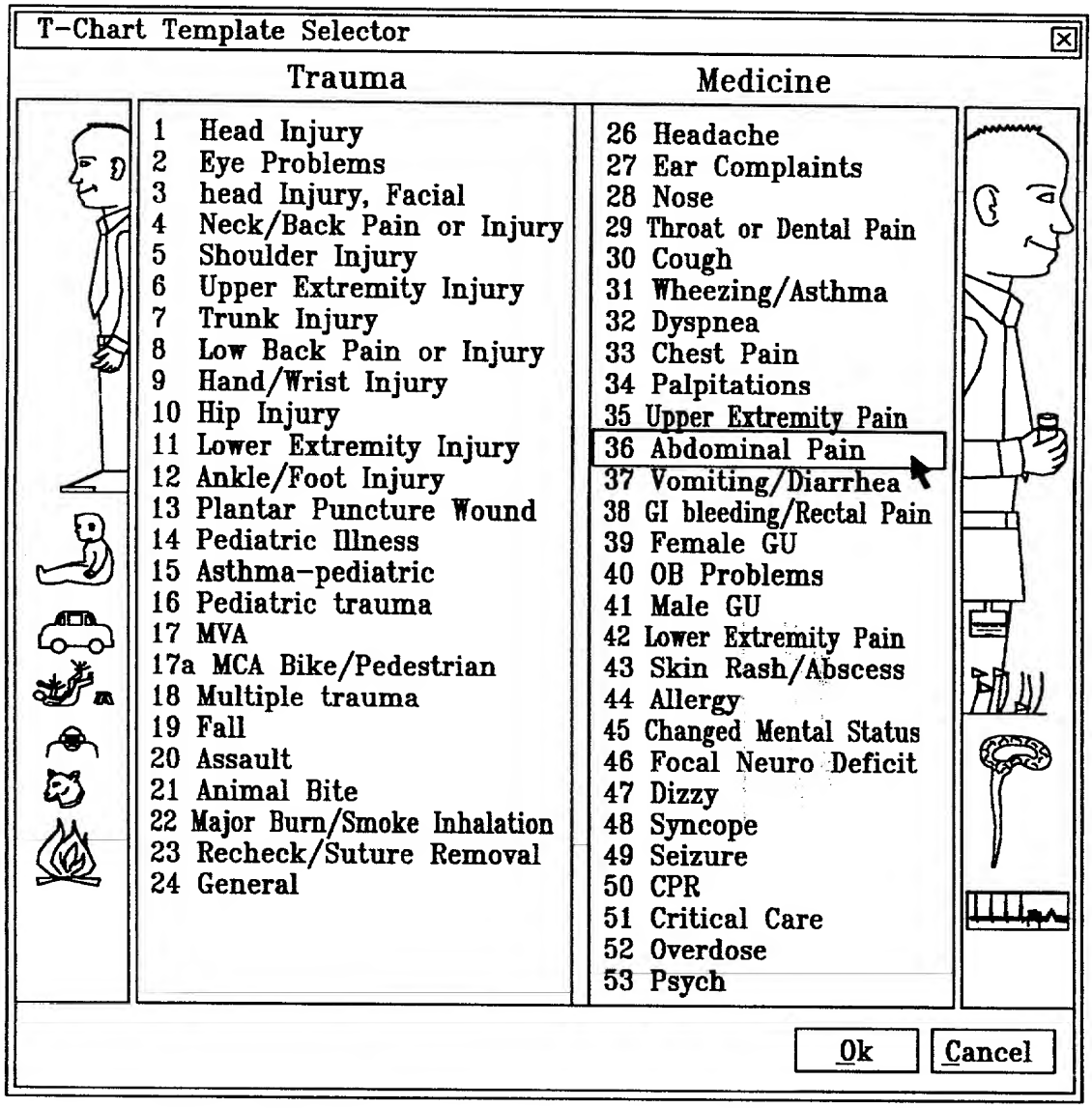

T-Chart Template Selector
Trauma
Medicine
1 Head Injury
2 Eye Problems
3 head Injury, Facial
4 Neck/Back Pain or Injury
5 Shoulder Injury
6 Upper Extremity Injury
7 Trunk Injury
8 Low Back Pain or Injury
9 Hand/Wrist Injury
10 Hip Injury
11 Lower Extremity Injury
12 Ankle/Foot Injury
13 Plantar Puncture Wound
14 Pediatric Illness
15 Asthma-pediatric
16 Pediatric trauma
17 MVA
17a MCA Bike/Pedestrian
18 Multiple trauma
19 Fall
20 Assault
21 Animal Bite
22 Major Burn/Smoke Inhalation
23 Recheck/Suture Removal
24 General
26 Headache
27 Ear Complaints
28 Nose
29 Throat or Dental Pain
30 Cough
31 Wheezing/Asthma
32 Dyspnea
33 Chest Pain
34 Palpitations
35 Upper Extremity Pain
36 Abdominal Pain
37 Vomiting/Diarrhea
38 GI bleeding/Rectal Pain
39 Female GU
40 OB Problems
41 Male GU
42 Lower Extremity Pain
43 Skin Rash/Abscess
44 Allergy
45 Changed Mental Status
46 Focal Neuro Deficit
47 Dizzy
48 Syncope
49 Seizure
50 CPR
51 Critical Care
52 Overdose
53 Psych
Ok
Cancel

FIG. 8


T-Chart Template Selector
Trauma
Medicine
1 Head Injury
2 Eye Problems
3 head Injury, Facial
4 Neck/Back Pain or Injury
5 Shoulder Injury
6 Upper Extremity Injury
7 Trunk Injury
8 Low Back Pain or Injury
9 Hand/Wrist Injury
10 Hip Injury
11 Lower Extremity Injury
12 Ankle/Foot Injury
13 Plantar Puncture Wound
14 Pediatric Illness
15 Asthma-pediatric
16 Pediatric trauma
17 MVA
17a MCA Bike/Pedestrian
18 Multiple trauma
19 Fall
20 Assault
21 Animal Bite
22 Major Burn/Smoke Inhalation
23 Recheck/Suture Removal
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34 Palpitations
35 Upper Extremity Pain
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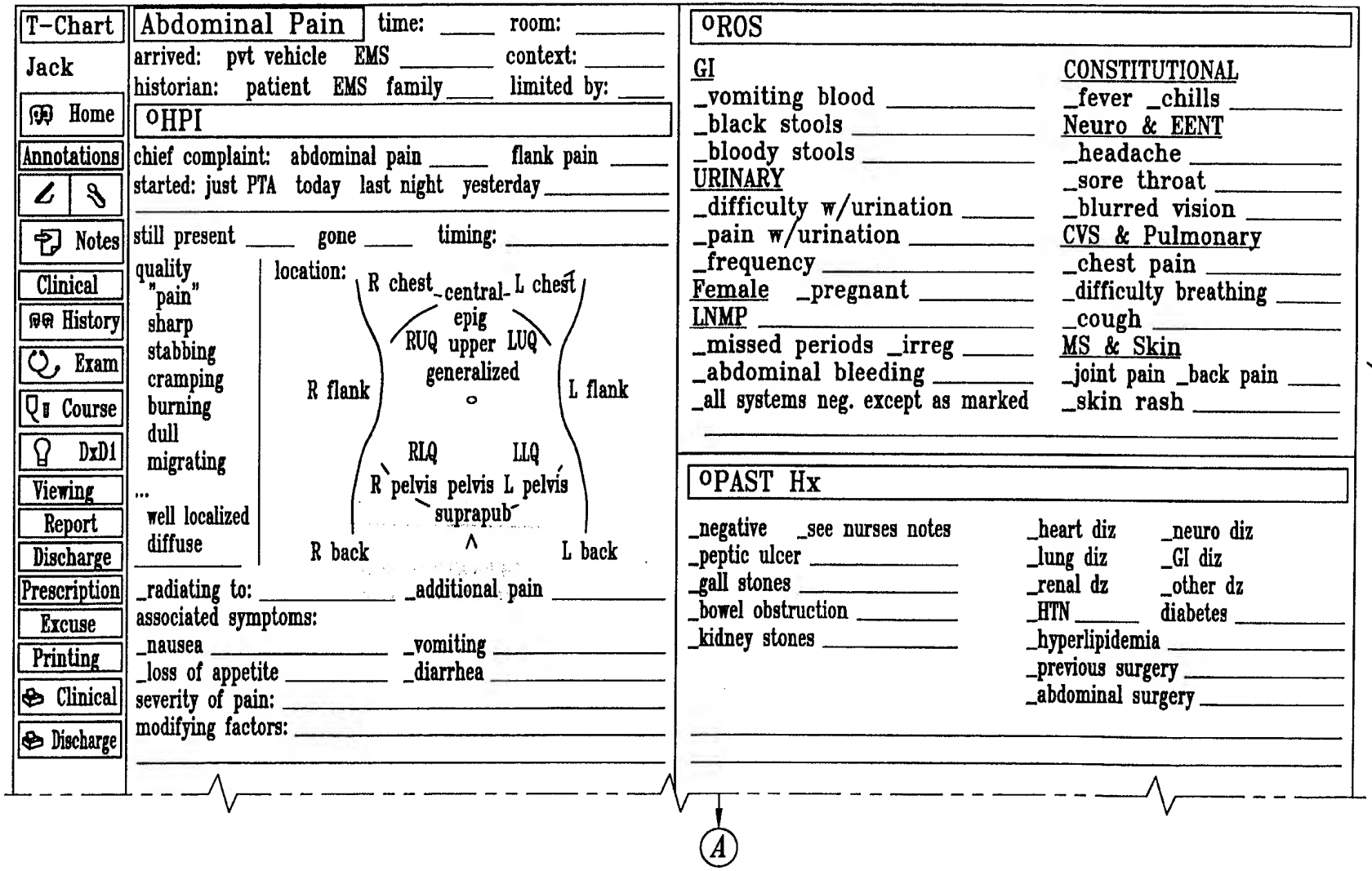
38 GI bleeding/Rectal Pain
39 Female GU
40 OB Problems
41 Male GU
42 Lower Extremity Pain
43 Skin Rash/Abscess
44 Allergy
45 Changed Mental Status
46 Focal Neuro Deficit
47 Dizzy
48 Syncope
49 Seizure
50 CPR
51 Critical Care
52 Overdose
53 Psych
Ok
Cancel

FIG. 9A



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Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 9B

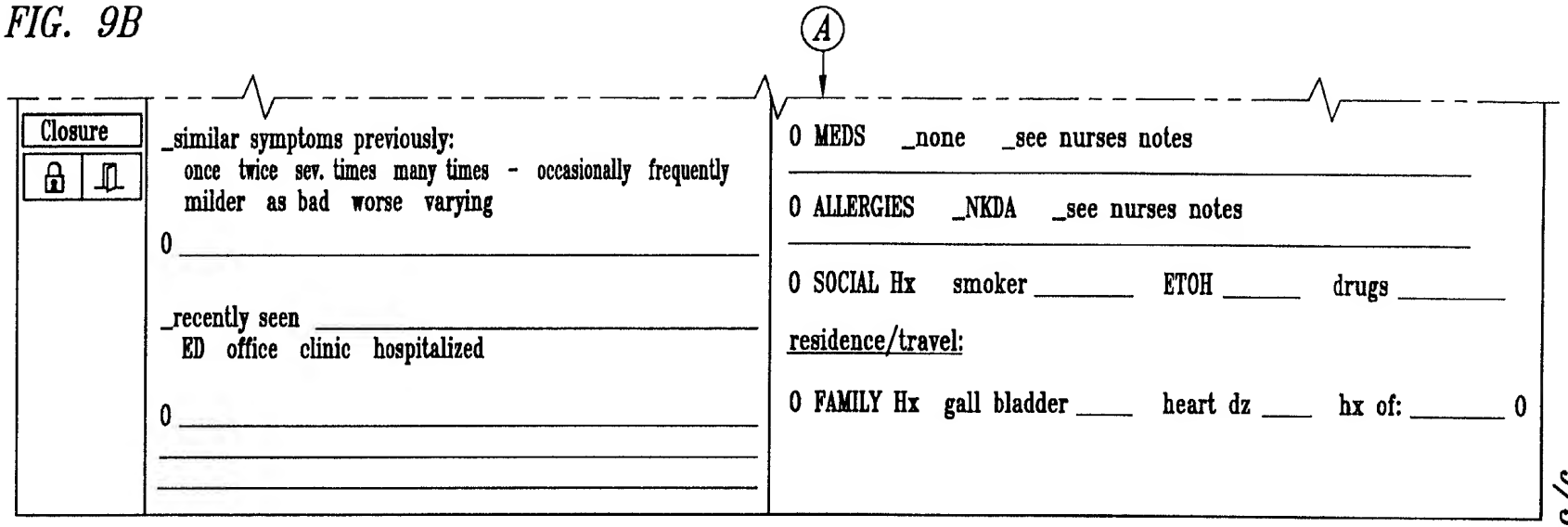
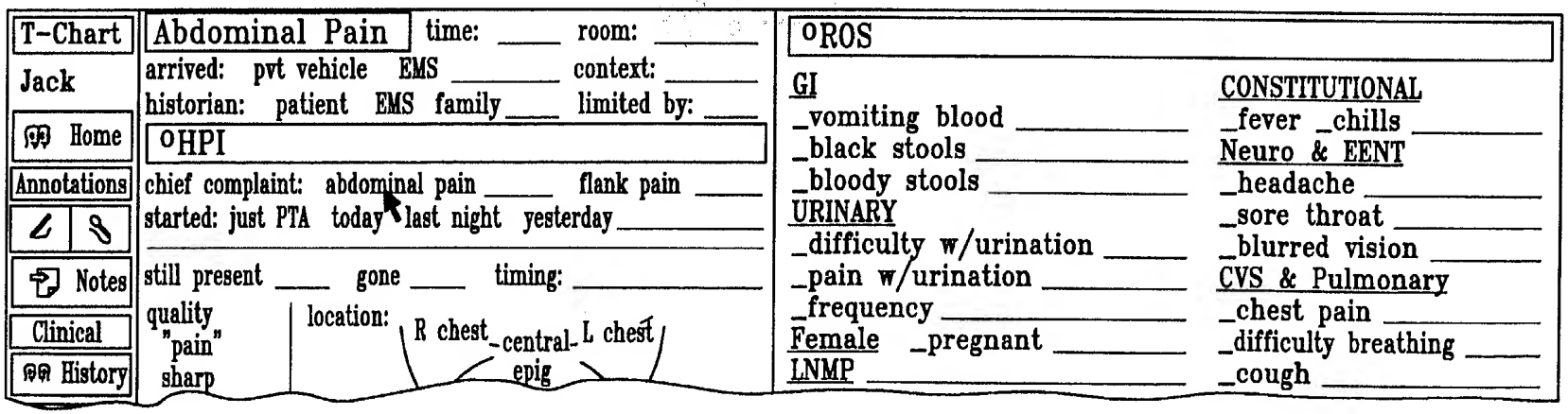


FIG. 10



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Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 11

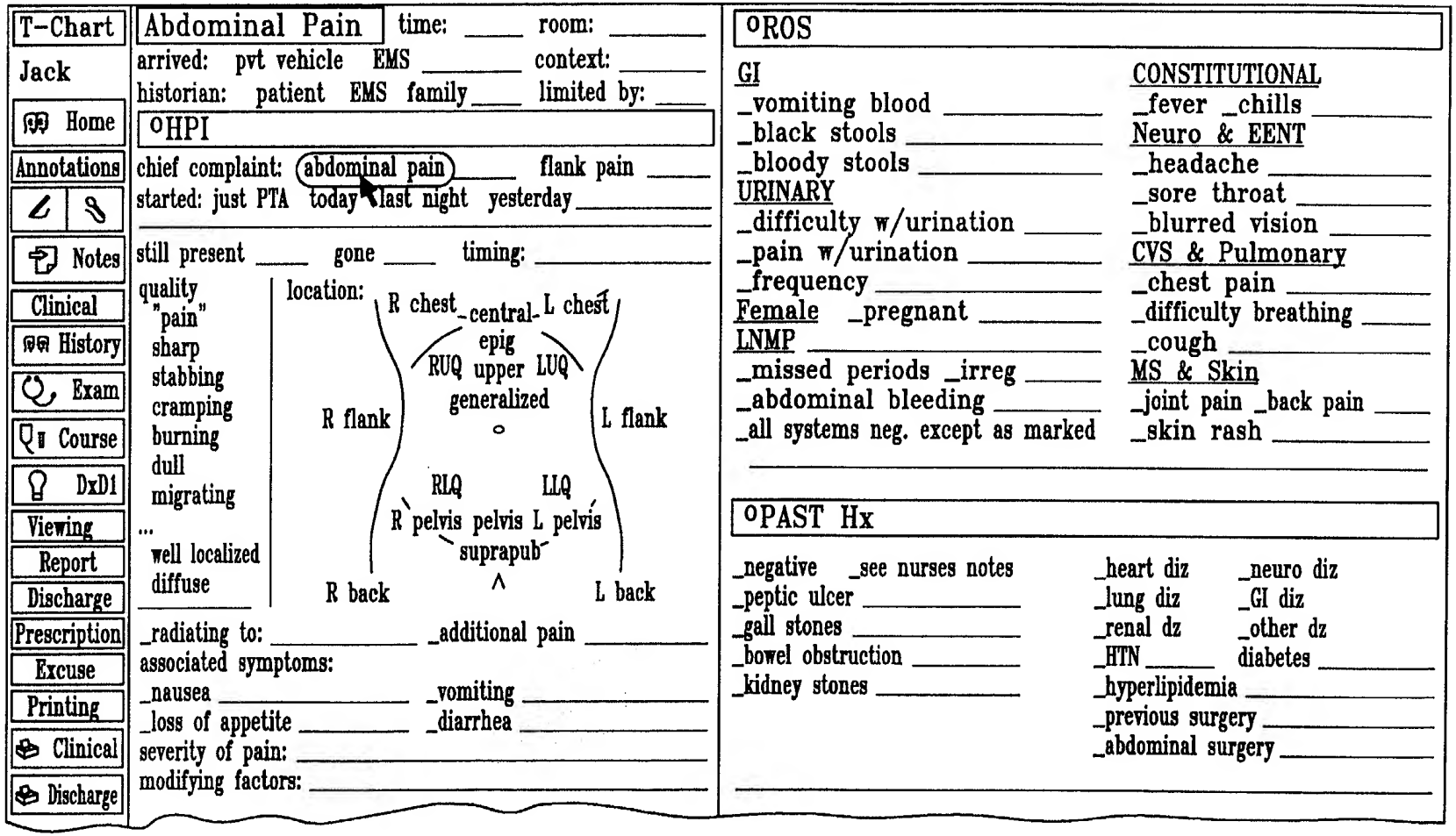
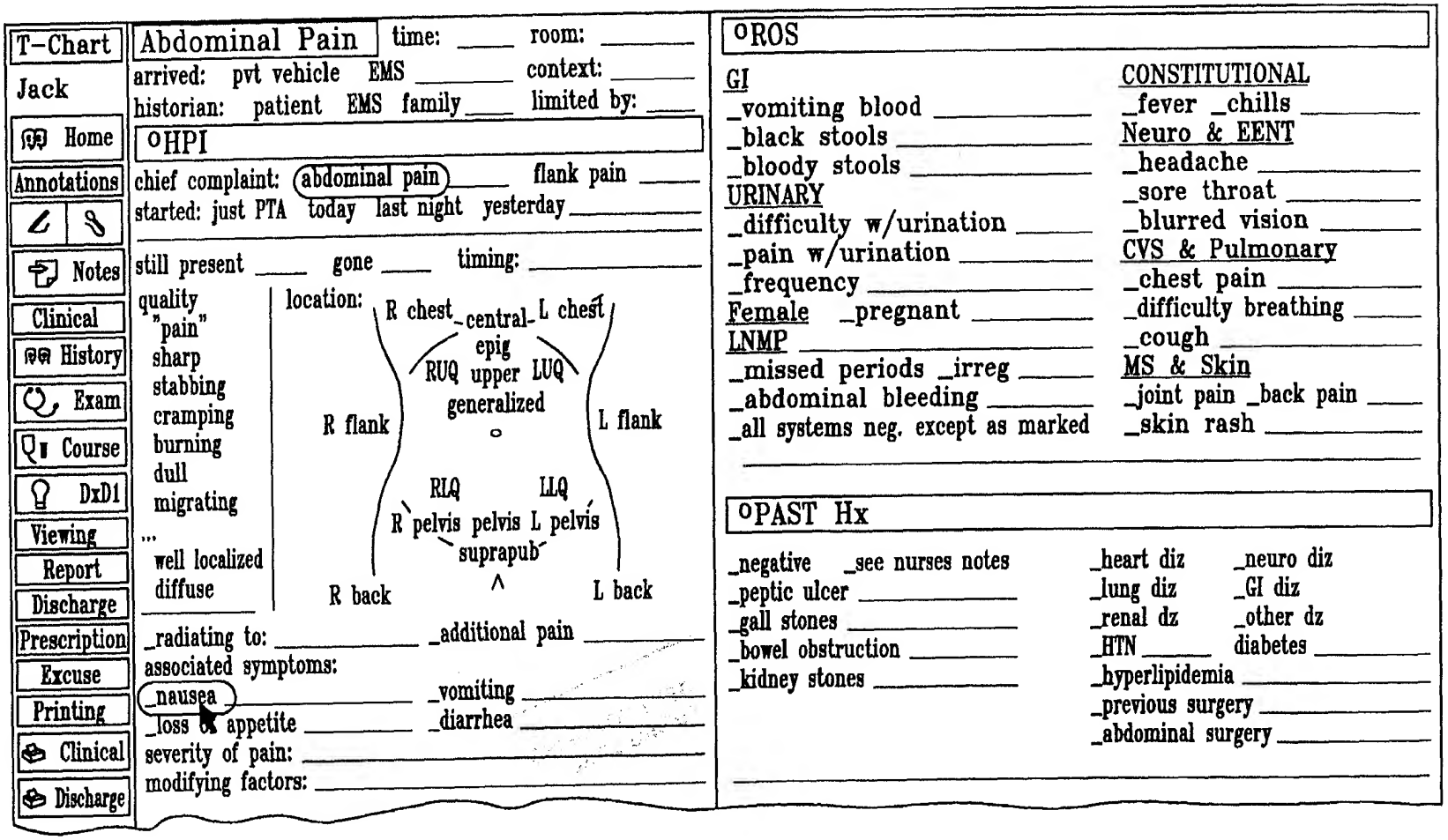


FIG. 12



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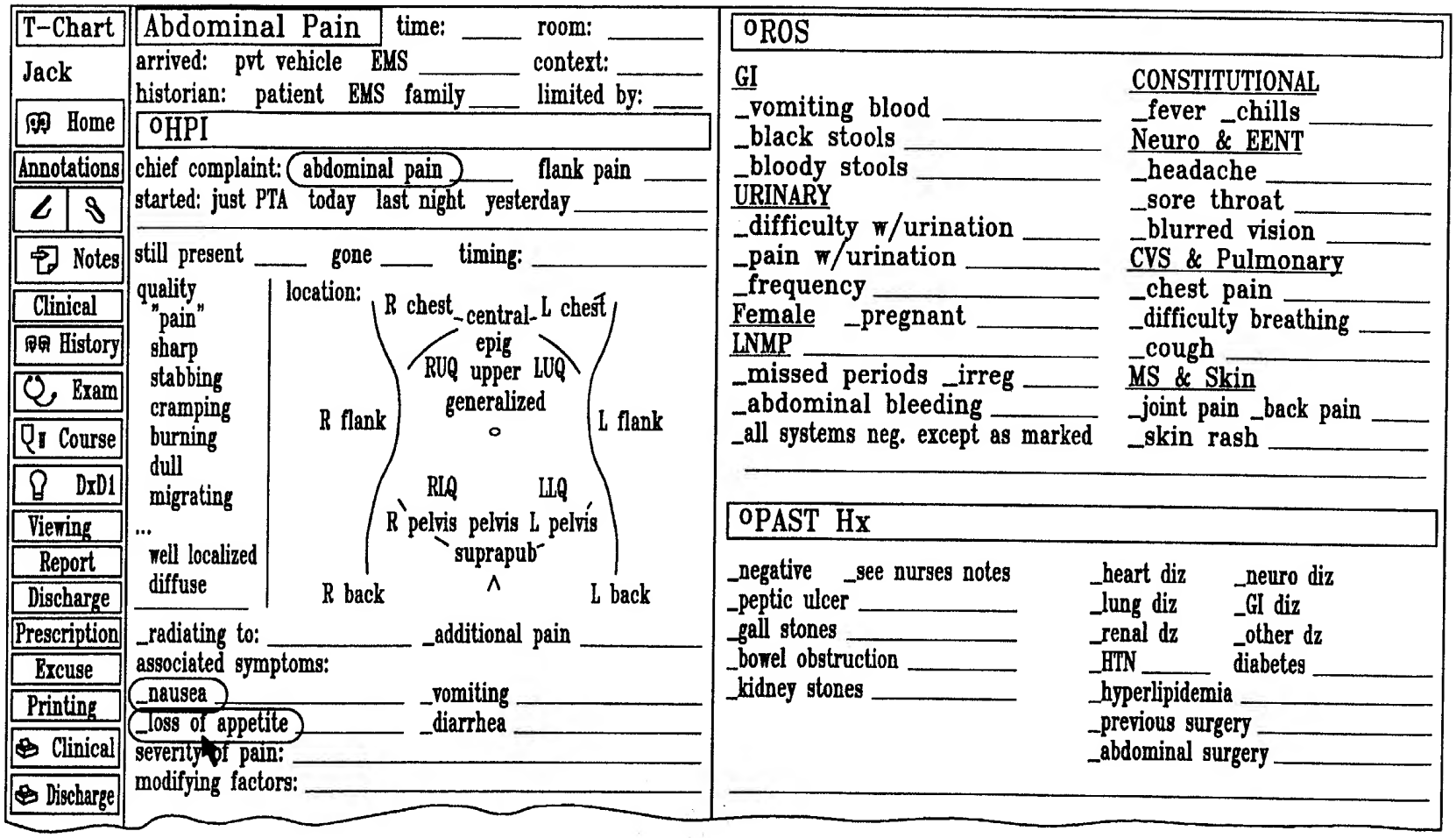
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 13



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Inventor(s): Woodrow W. Gandy et al
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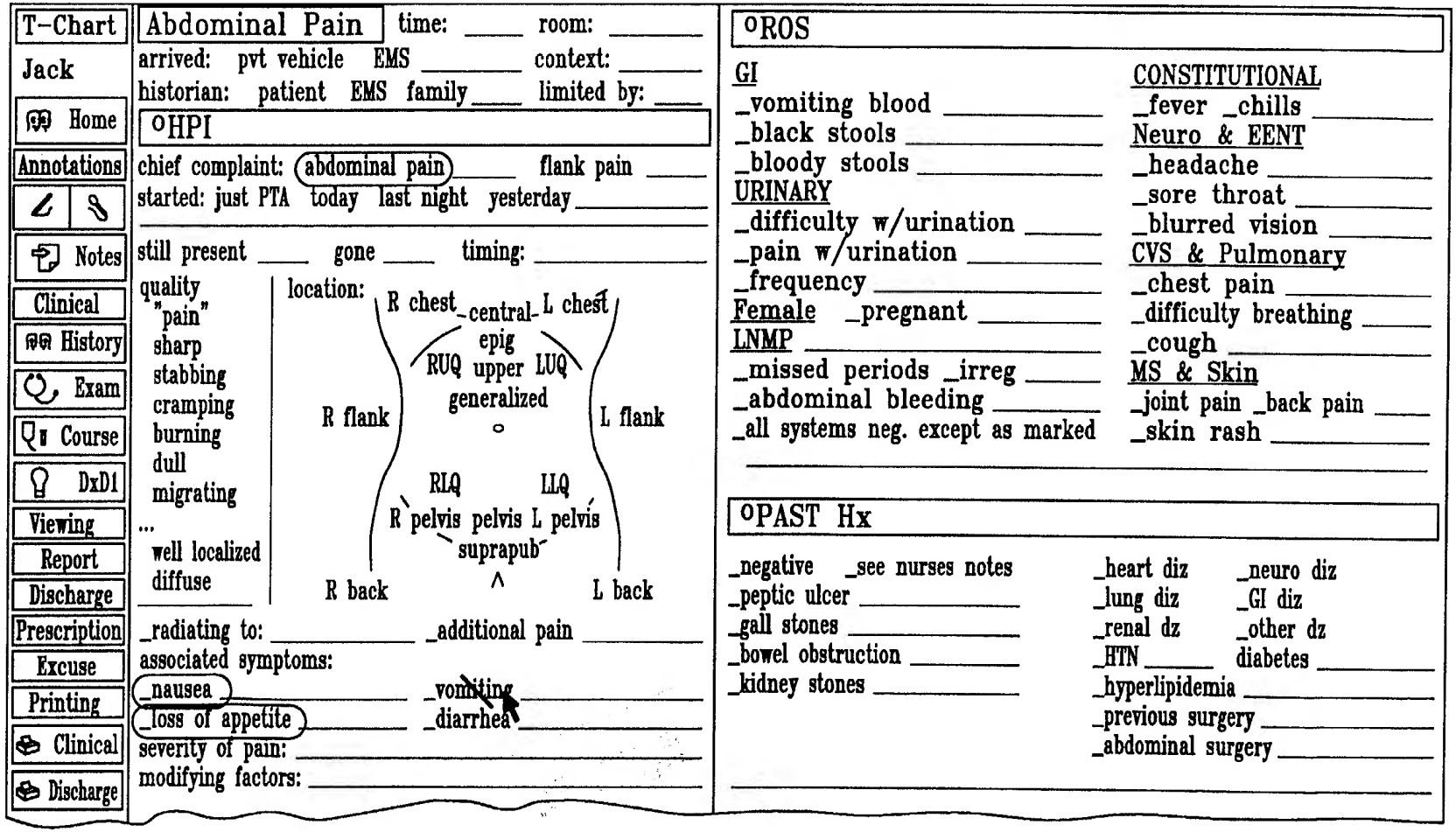
FIG. 14



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Inventor(s): Woodrow W. Gandy et al
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FIG. 15

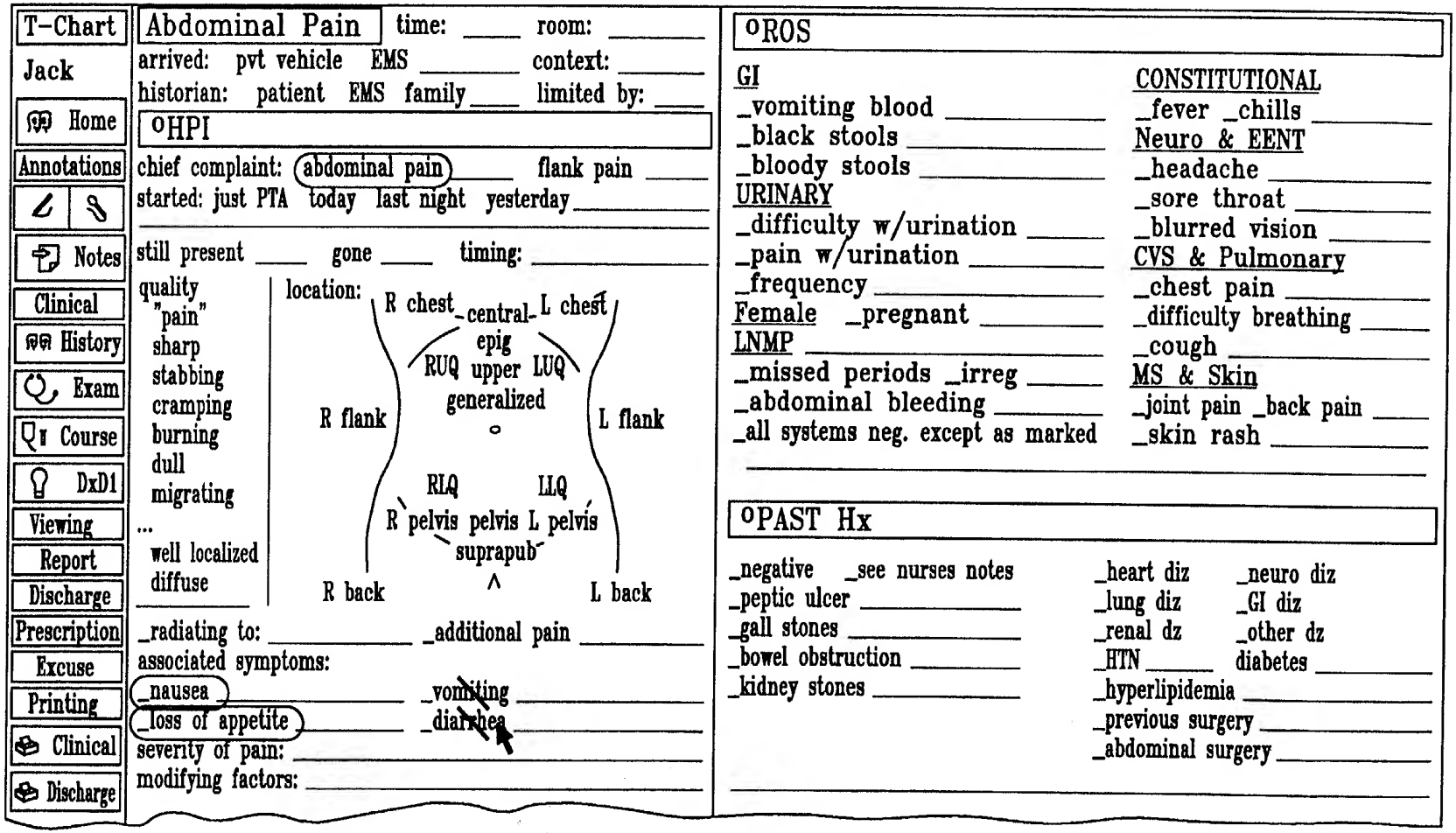


FIG. 16

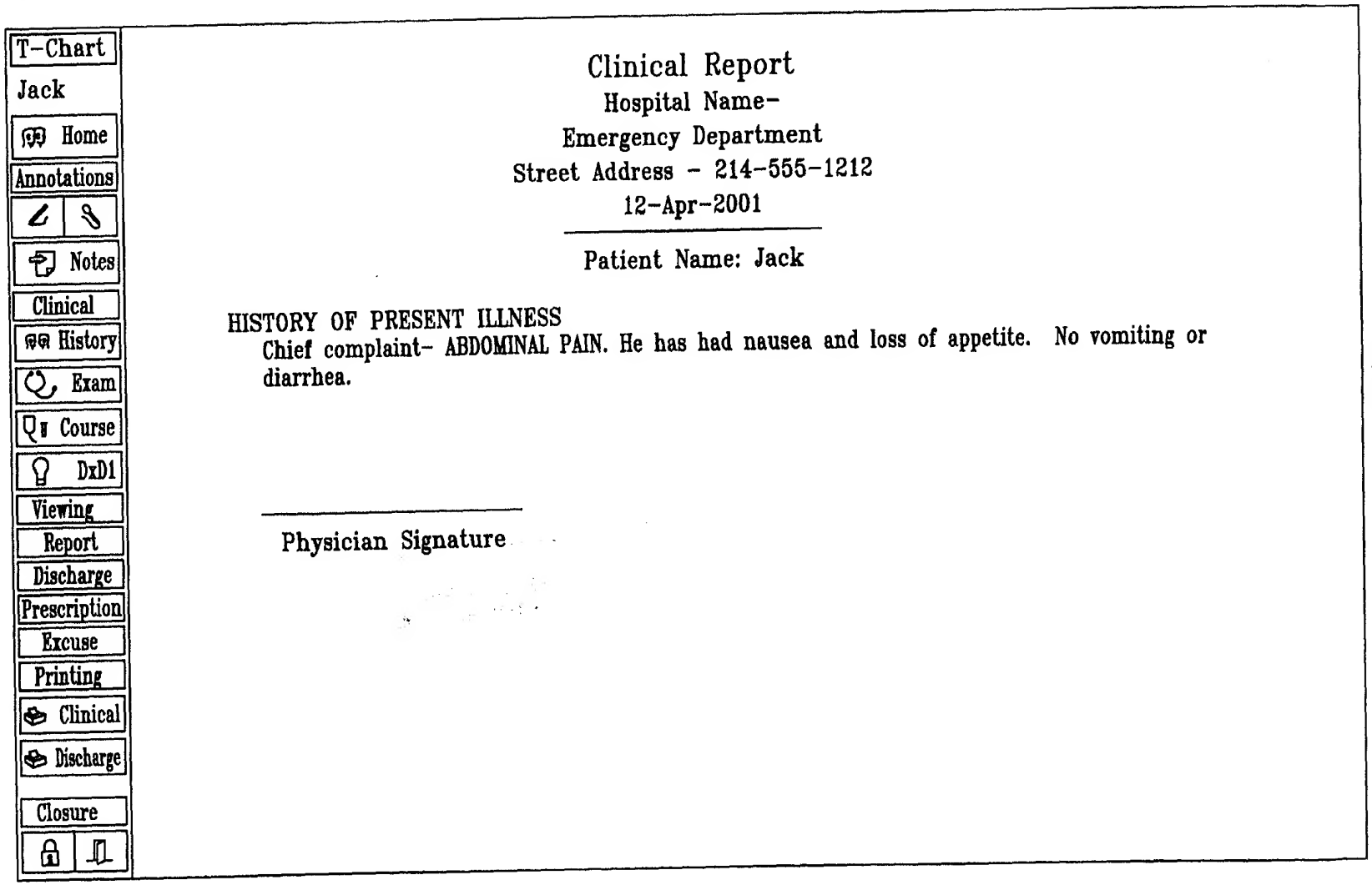
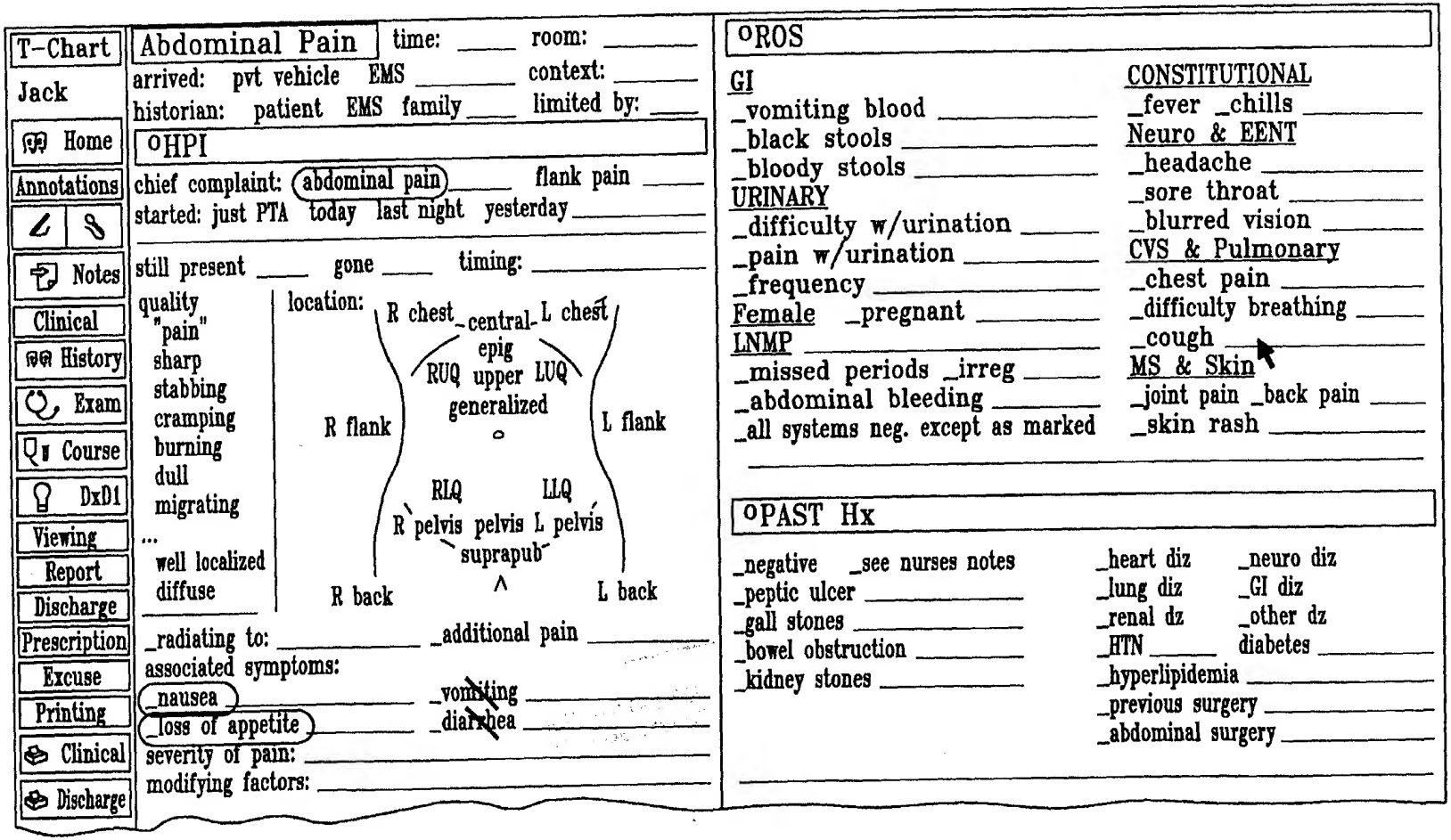


FIG. 17



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Inventor(s): Woodrow W. Gandy et al
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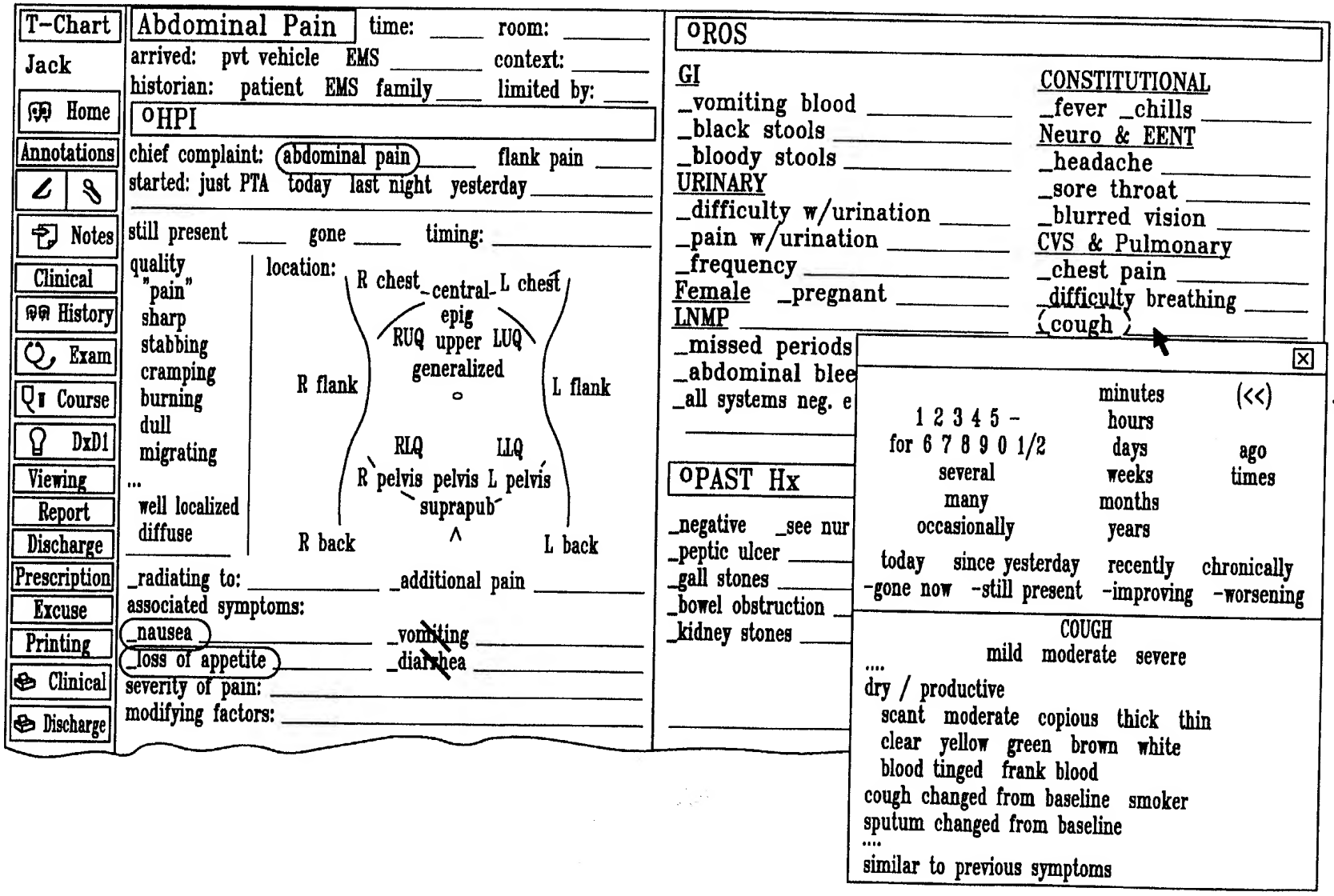
FIG. 18



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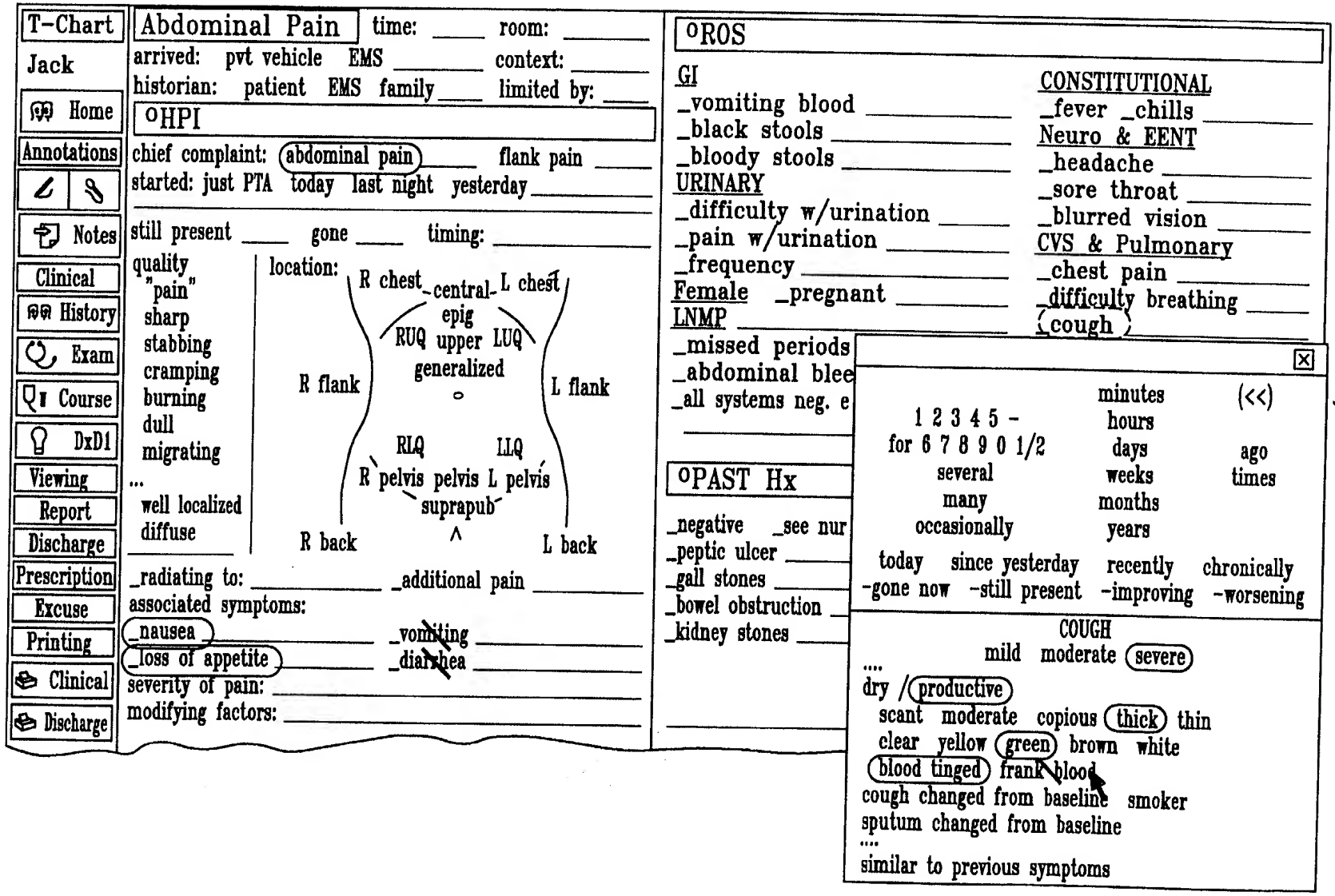
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 19



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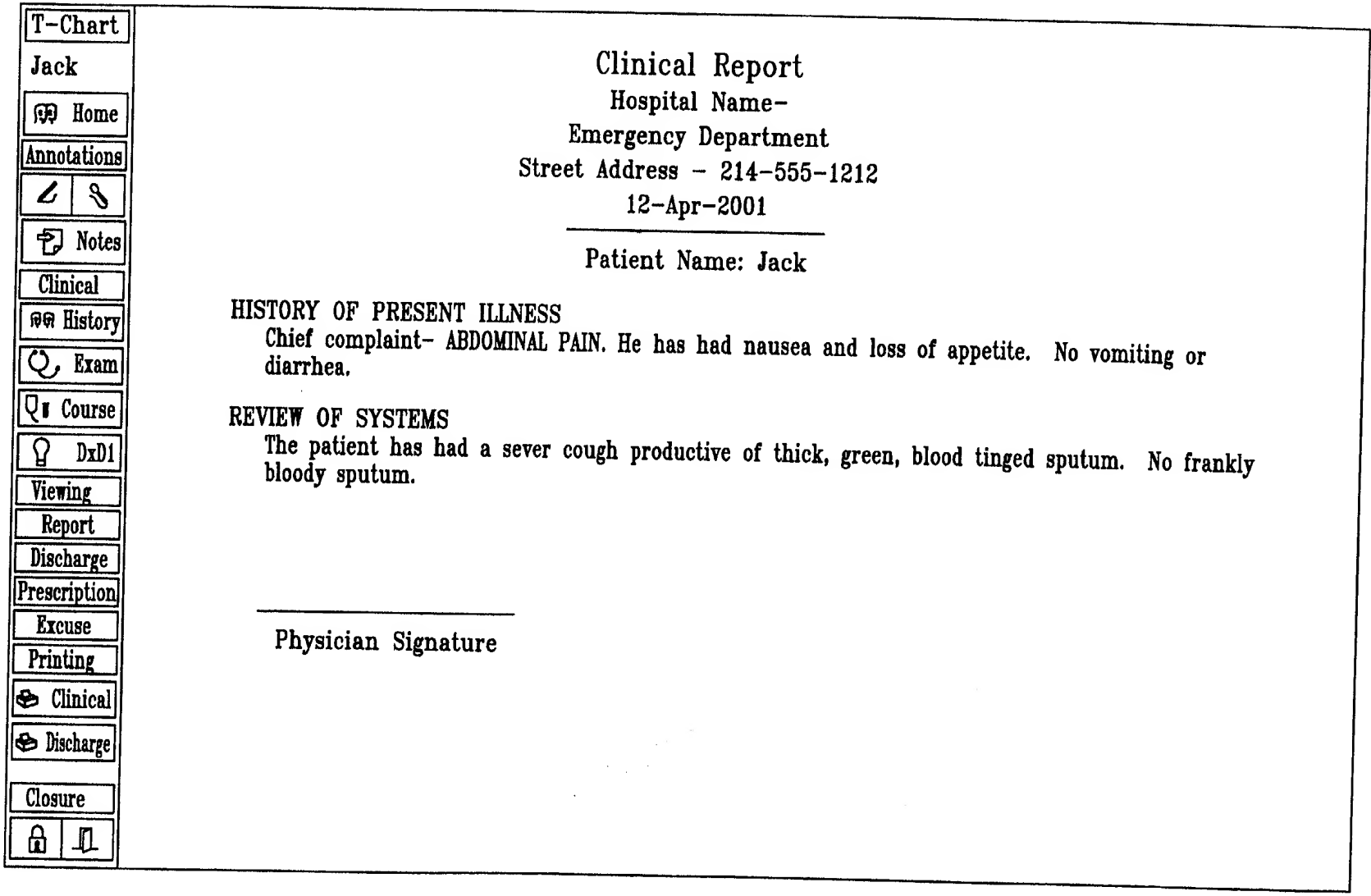
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 20



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Inventor(s): Woodrow W. Gandy et al
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TSYS 25,410
Title: METHOD FOR ENTERING, RECORDING, DISTRIBUTING AND REPORTING DATA
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 21

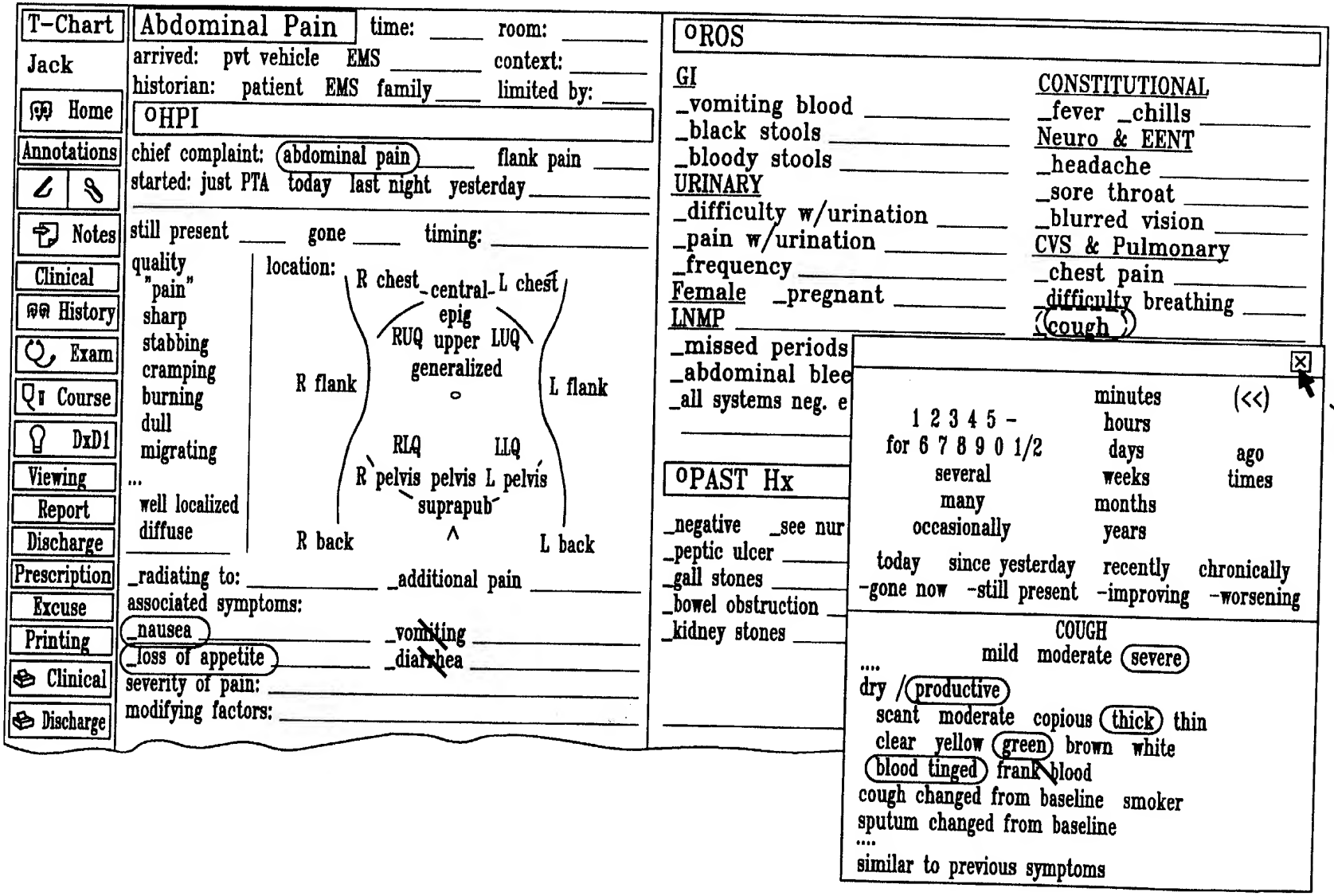
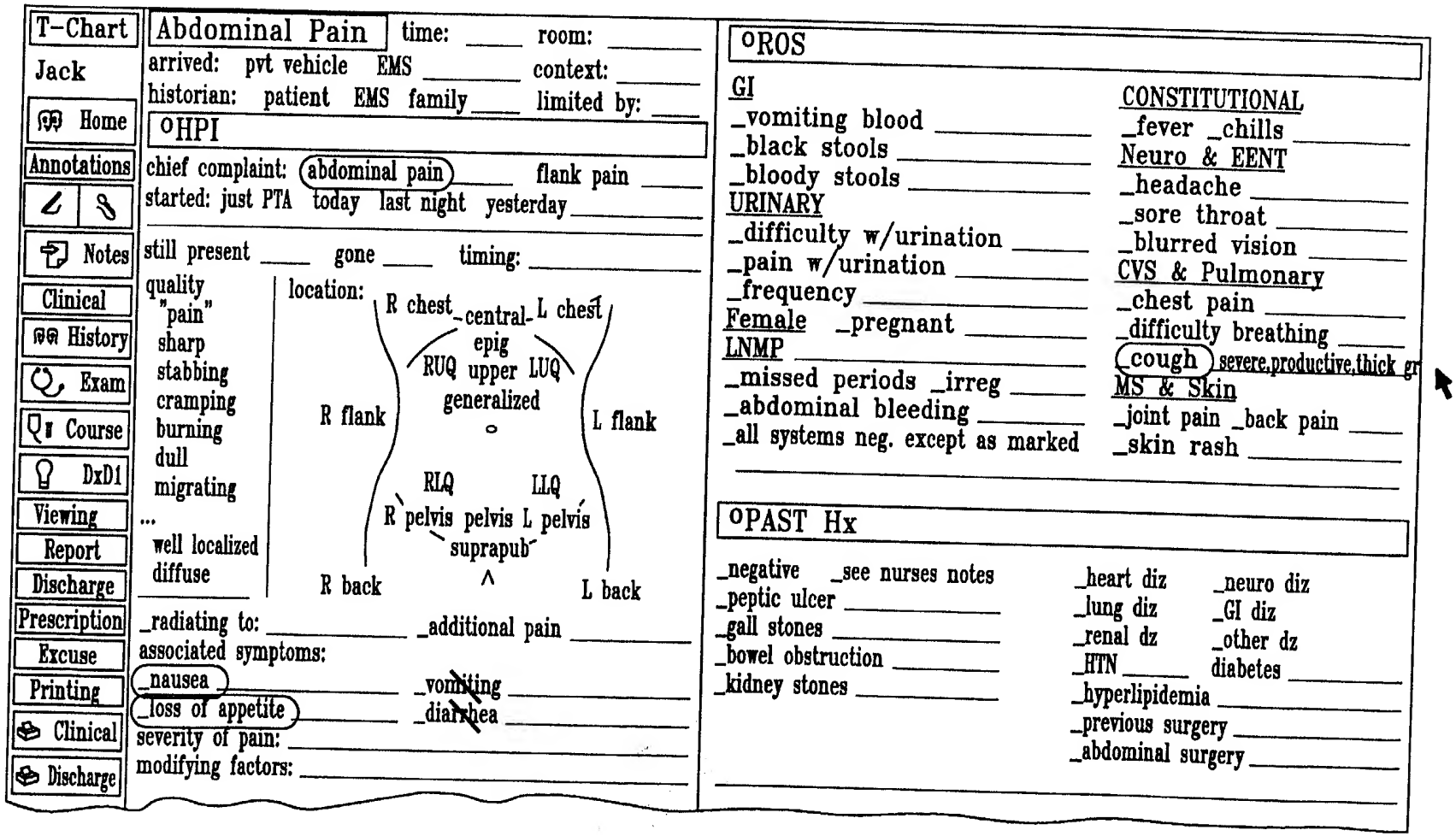


FIG. 22



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Inventor(s): Woodrow W. Gandy et al
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FIG. 23

T-Chart
Jim
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

MVA time: _____ room: _____
arrived: pvt vehicle EMS _____ context: _____
historian: patient EMS family ____ limited by: _____

OHPI
chief complaint: MVA _____
location of injuries: _____
occurred: just PTA today last night yesterday _____
pain: none ____ mild ____ moderate ____ severe _____
assoc: blow head ___ neck pain __ LOC __ dazed __ seizure __
mechanism details: 0

OROS
_numbness _weakness__ _trouble breathing _____
_hearing loss _____ _nausea _vomiting _____
_loss of vision _____ _bladder dysfunction _____
_headache _____ _skin laceration _____
_chest pain _____ _fever _recently ill _____
_depressed _____ _all systems neg. except as marked

OPAST HISTORY
_neg _see nurses notes _heart dz _neuro dz ____
tetenus: UTD >5 >10 unk __ _lung dz _GI dz _____
_____ _renal dz _other dz ____
_____ _HTN ___ diabetes _____
_____ _previous surgery _____
0 MEDS _none _see nurses notes _____
0 ALLERGIES _NKDA _see nurses notes _____

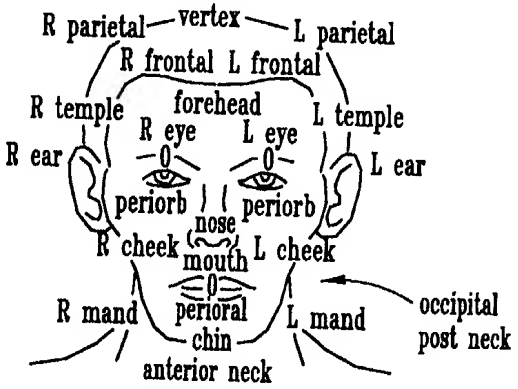
0 SOCIAL HX smoker_____ ETOH _____ drugs ____
residence/travel: _____ 0

bkbrd c-collar____ nurses notes rev'd _____ VS rev'd _____

PHYSICAL EXAM

_alert
_NAD
_anxious / lethargic / obtunded _____
_in distress mild mod severe _____

HEAD
_non-tender
_no swelling
_Battle's sign _____ raccoon eyes _____



Add'l Injury 0

NECK
_non-tender
_painless ROM
_verteb. tenderness ___ painful movement _____
_decrsd ROM _____ muscle spasm _____

EYES
_PERRL
_EOM intact
_pupillary exam: _____
_ocular injury _____
_abnml fundiscopic _____

ENT
_no dental injury
_phatynx nml
_hematympanum _____
_malocclusion _____

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22/36

FIG. 24

T-Chart
Jim
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

RESPIRATORY
_chest nontender
_breath snds nml
_resp distress
_chest wall injury #1 #2
_decreased breath sounds
_rales rhonchi
_wheezes crepitus

CVS
_heart snds nml
_pulses nml
_abnml rate tachycardia bradycardia
_abnml rhythm
_JVD present
_extra sounds murmur
_pulse exam

ABDOMEN
_soft
_nontender
_no organomegaly
_obese scar other
_tenderness #1 #2
_guarding
_rebound
_organomegaly gravid uterus
_abnml bowel sounds
_distention
_mass

GU
_nml genitalia
_nml vaginal exam
_panneal hematoma
_blood at urethral meatus

RECTAL
_nml rectal exam
_heme neg stool
_blood in stool
_abnormal digital rectal

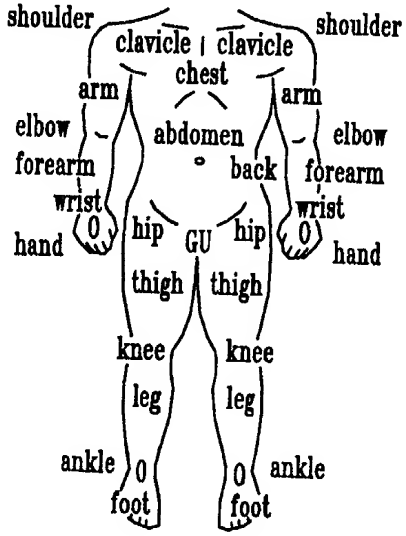
BACK
_nontender
_ROM nml
_tenderness #2
_vertebral point tenderness
_muscle spasm limited ROM

0 NEURO
_oriented x3
_no motor deficit
_no sensory deficit
_reflexes nml
_altered mental status GCS
_CN deficit
_weakness sensory deficit
_reflex exam:

SKIN
_intact
_warm, dry
_nml color
_cyanosis pallor
_cool skin diaphoresis
_skin rash poor skin turgor

EXTREMITIES
_atraumatic
_nml inspection
_pelvis stable
_no pedal edema
_soft tissue tenderness
_bony tenderness
_abrasions #1 #2
_limping gait cannot bear weight
_gait not tested due to pain

RT



LT

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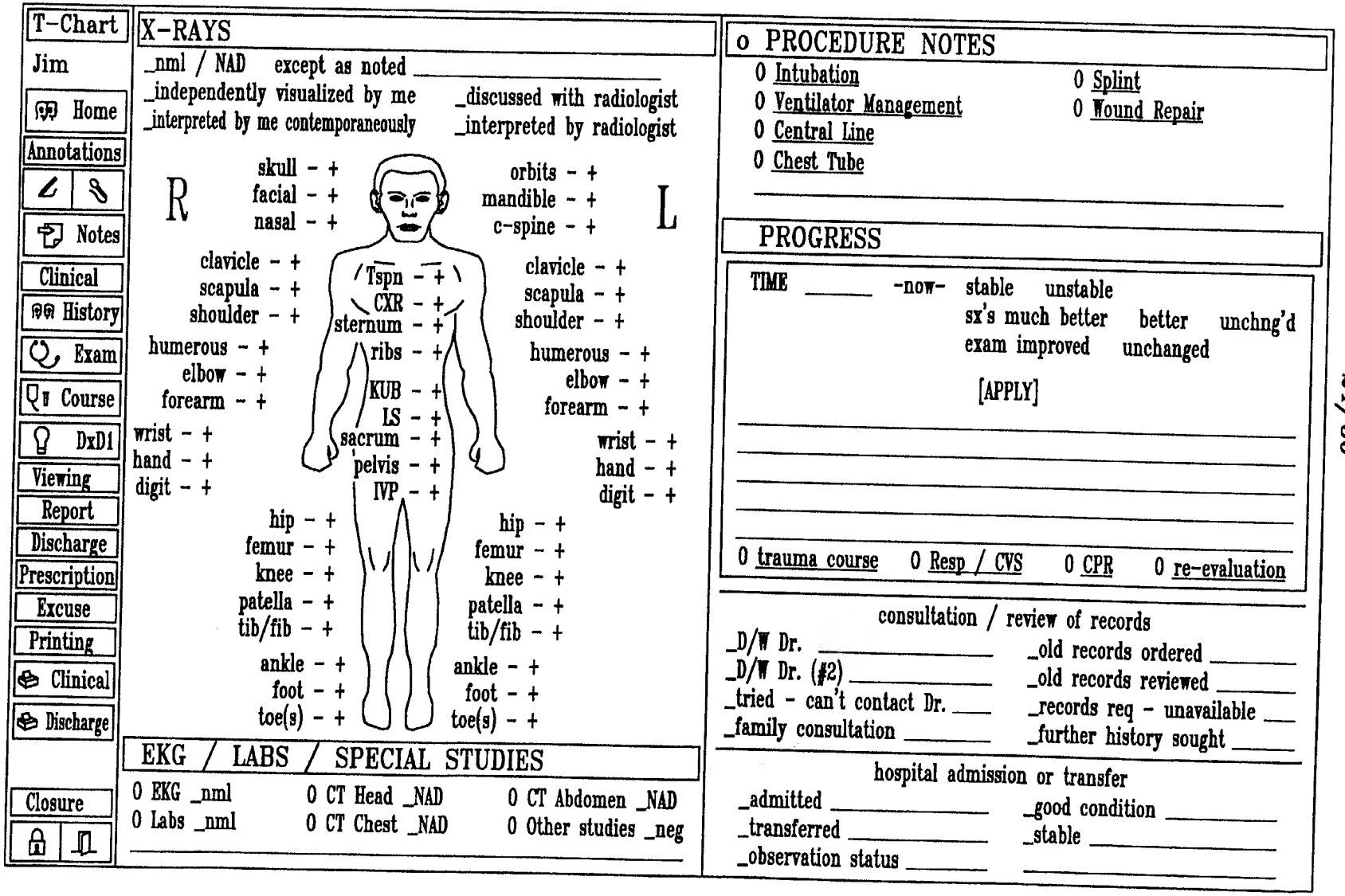
Title:METHOD FOR ENTERING, RECORDING, DISTRIBUTING AND REPORTING DATA
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 25



TSYS 25,410
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Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 26

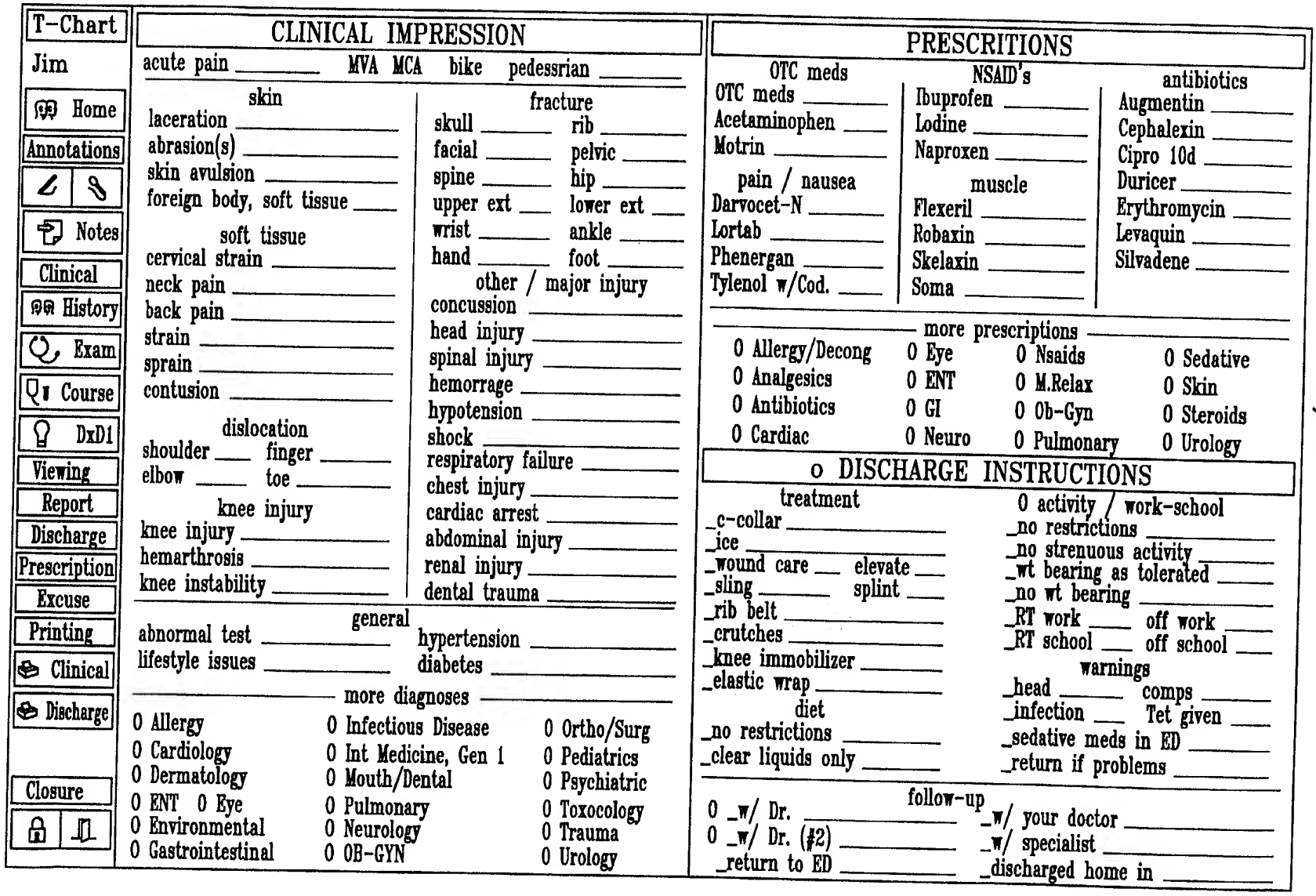
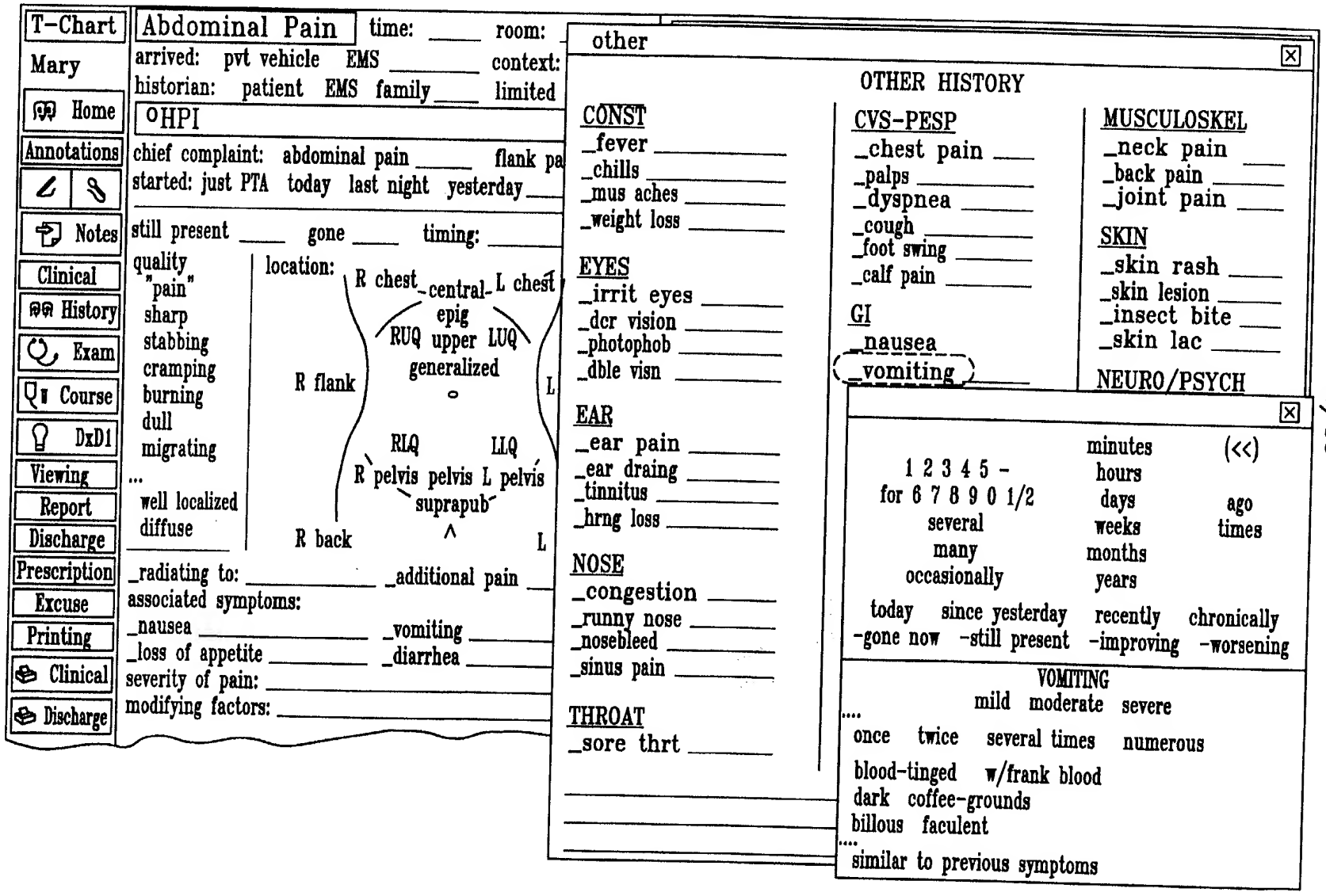


FIG. 27



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Inventor(s): Woodrow W. Gandy et al
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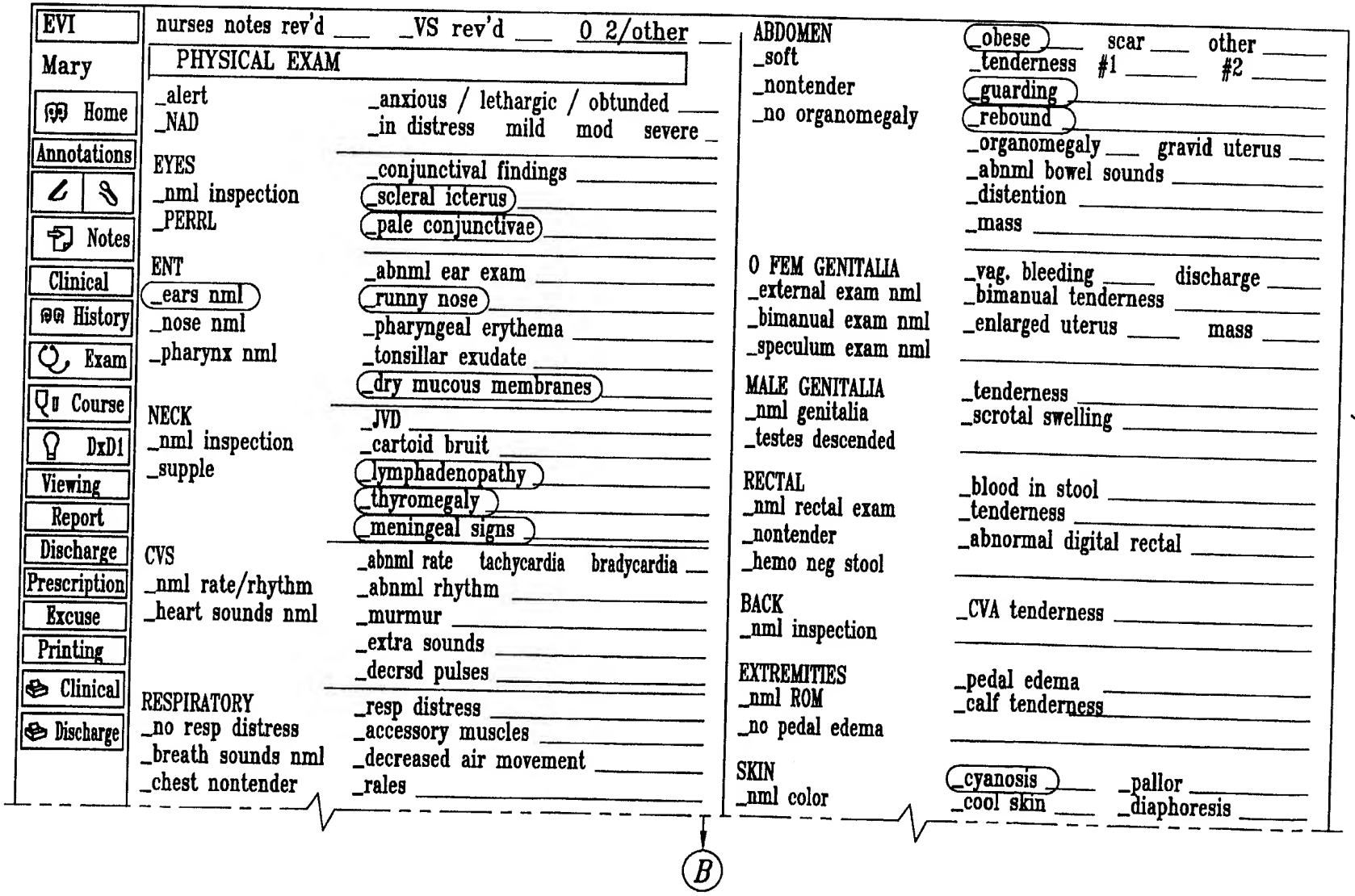
FIG. 28A



TSYS 25,410
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Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 28B

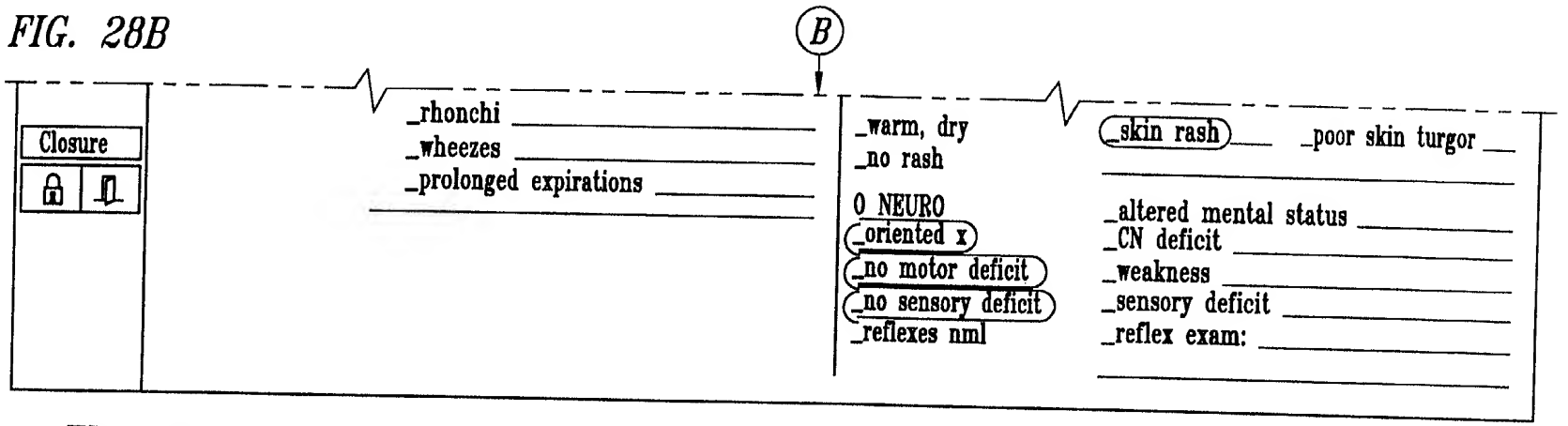


FIG. 29

Clinical Report

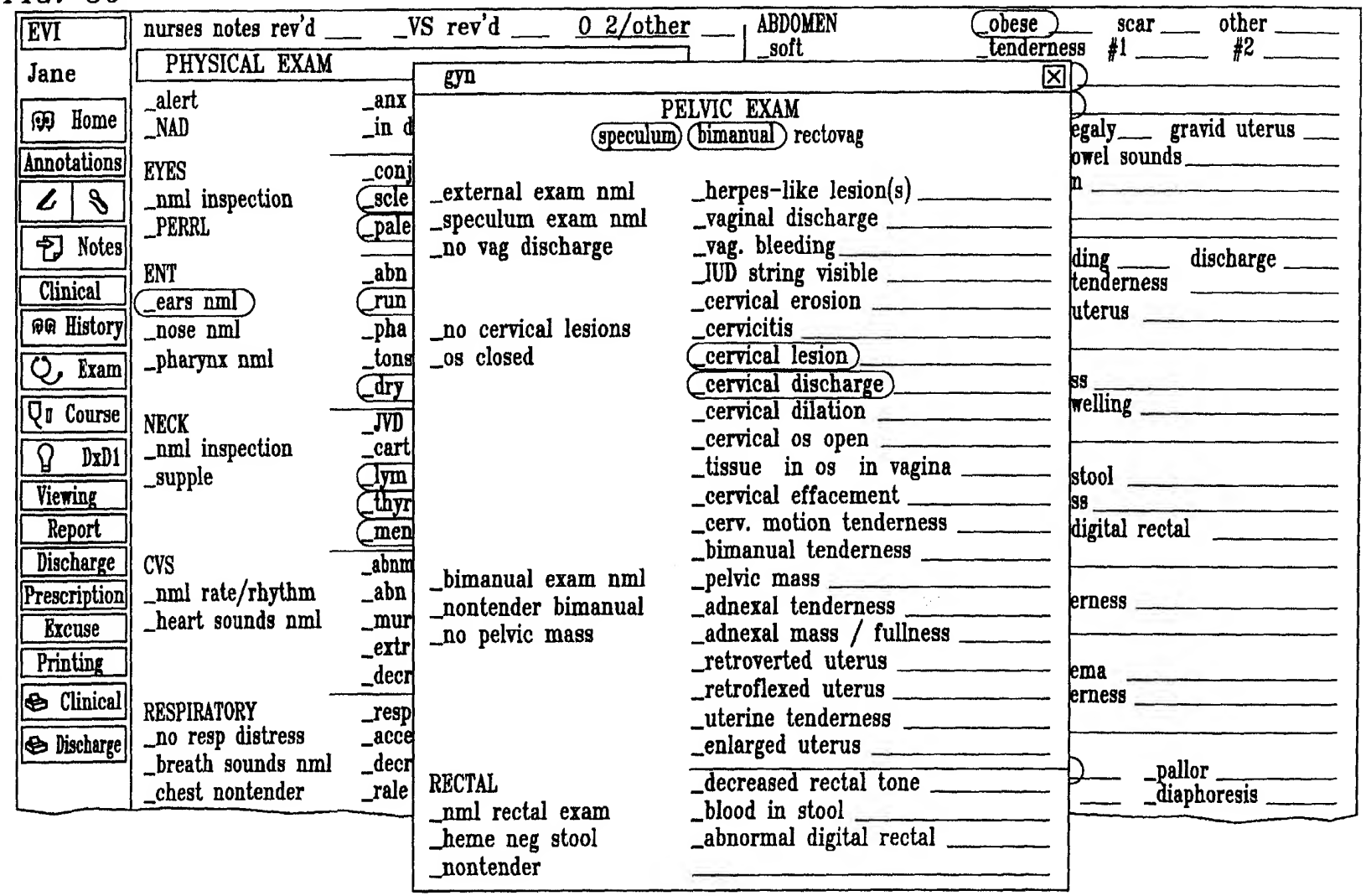
Hospital Name - Emergency Department
Street Address - 214-555-1212
12-Apr-2001

Patient Name: Mary

PHYSICAL EXAM
Eyes: Scleral icterus. Pale conjunctivae.
ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.
Abdomen: Obese. Rebound tenderness. Guarding present.
Skin: Cyanosis. Skin rash.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

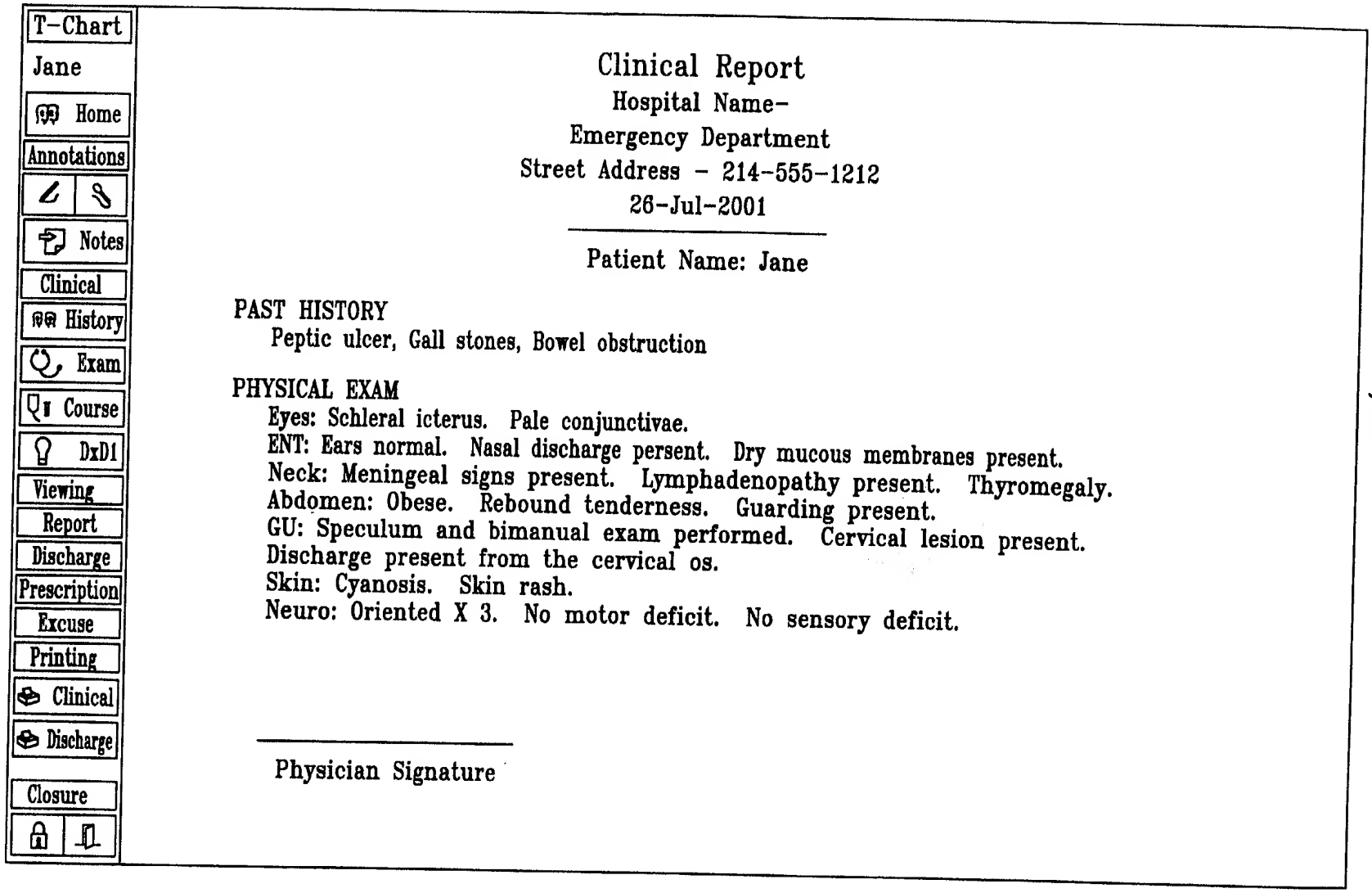
Physician Signature

FIG. 30



TSYS 25,410
Title:METHOD FOR ENTERING, RECORDING, DISTRIBUTING AND REPORTING DATA
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 31



Clinical Report

Hospital Name-
Emergency Department
Street Address - 214-555-1212
26-Jul-2001

Patient Name: Jane

PAST HISTORY

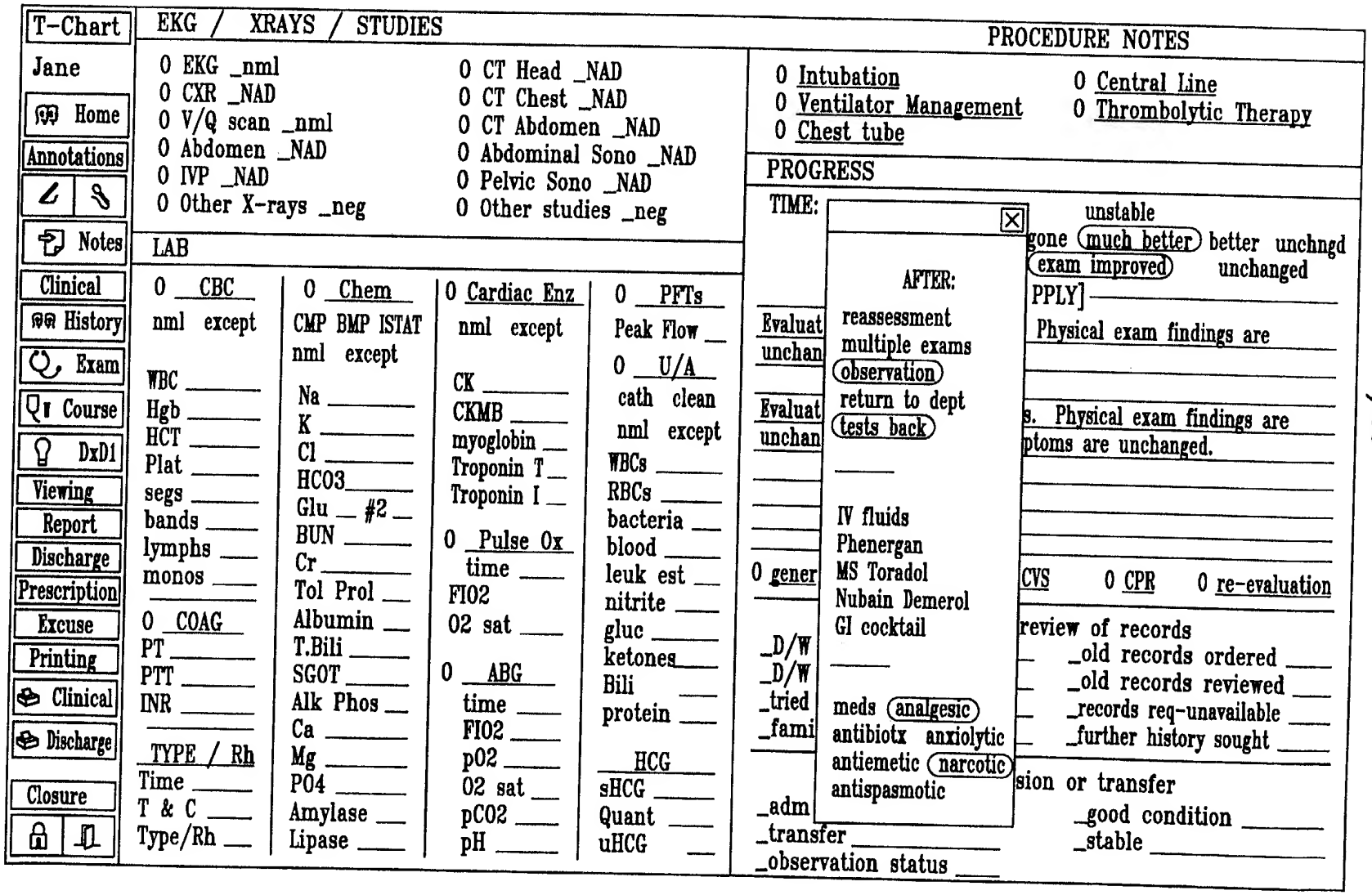
Peptic ulcer, Gall stones, Bowel obstruction

PHYSICAL EXAM

Eyes: Schleral icterus. Pale conjunctivae.
ENT: Ears normal. Nasal discharge persent. Dry mucous membranes present.
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.
Abdomen: Obese. Rebound tenderness. Guarding present.
GU: Speculum and bimanual exam performed. Cervical lesion present.
Discharge present from the cervical os.
Skin: Cyanosis. Skin rash.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

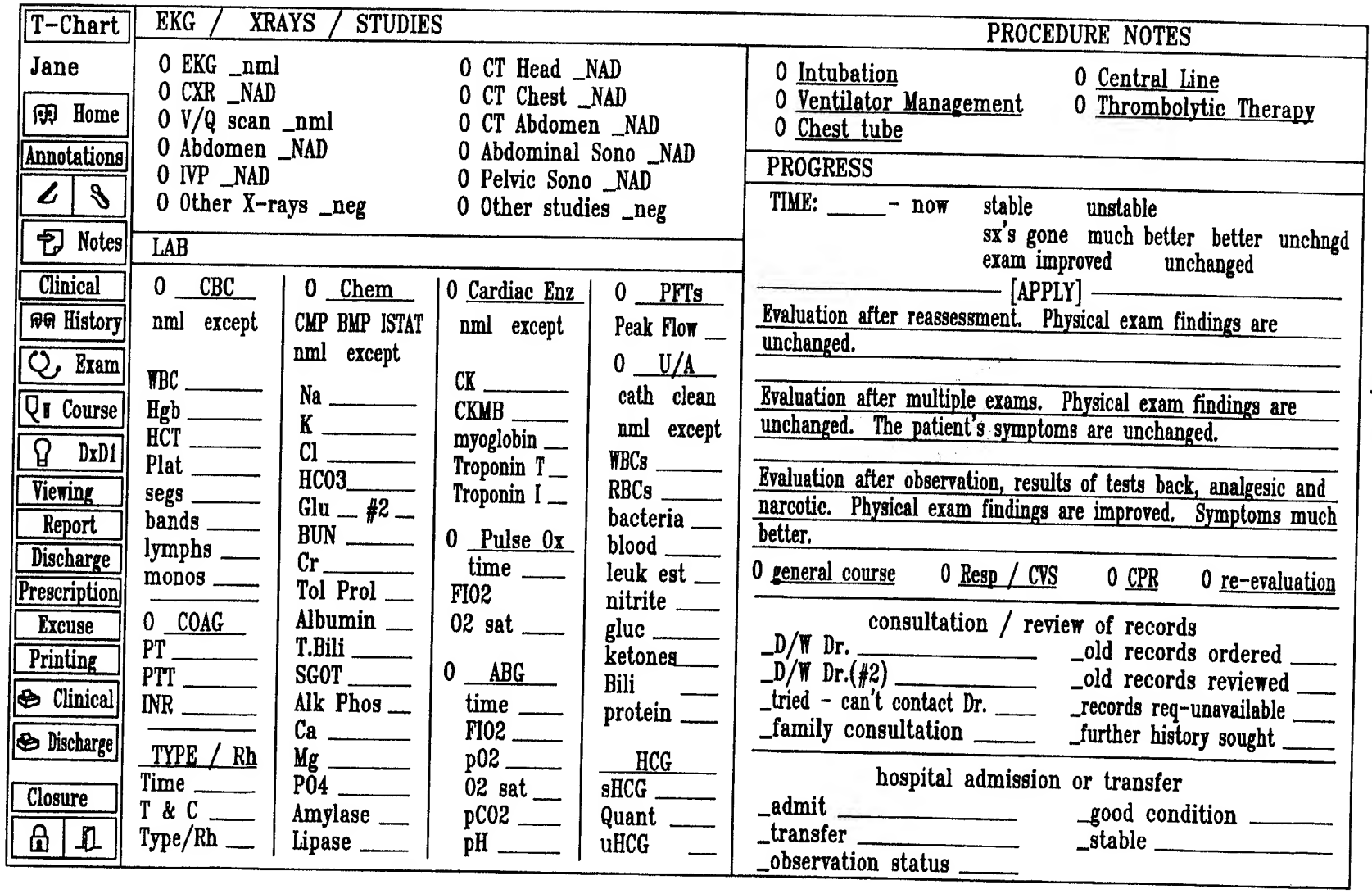
Physician Signature

FIG. 32



TSYS 25,410
Title:METHOD FOR ENTERING, RECORDING, DISTRIBUTING AND REPORTING DATA
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 33



T-Chart
Jane
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

EKG / XRAYS / STUDIES

0 EKG _nml
0 CXR _NAD
0 V/Q scan _nml
0 Abdomen _NAD
0 IVP _NAD
0 Other X-rays _neg
0 CT Head _NAD
0 CT Chest _NAD
0 CT Abdomen _NAD
0 Abdominal Sono _NAD
0 Pelvic Sono _NAD
0 Other studies _neg

LAB

0 CBC
nml except
WBC
Hgb
HCT
Plat
segs
bands
lymphs
monos

0 COAG
PT
PTT
INR

TYPE / Rh
Time
T & C
Type/Rh

0 Chem
CMP BMP ISTAT
nml except
Na
K
Cl
HCO3
Glu #2
BUN
Cr
Tol Prol
Albumin
T.Bili
SGOT
Alk Phos
Ca
Mg
PO4
Amylase
Lipase

0 Cardiac Enz
nml except
CK
CKMB
myoglobin
Troponin T
Troponin I

0 Pulse Ox
time
FIO2
02 sat

0 ABG
time
FIO2
pO2
02 sat
pCO2
pH

0 PFTs
Peak Flow
0 U/A
cath clean
nml except
WBCs
RBCs
bacteria
blood
leuk est
nitrite
gluc
ketones
Bili
protein

HCG
sHCG
Quant
uHCG

PROCEDURE NOTES

0 Intubation
0 Ventilator Management
0 Chest tube
0 Central Line
0 Thrombolytic Therapy

PROGRESS

TIME: _____- now stable unstable
sx's gone much better better unchngd
exam improved unchanged
[APPLY]

Evaluation after reassessment. Physical exam findings are unchanged.

Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.

Evaluation after observation, results of tests back, analgesic and narcotic. Physical exam findings are improved. Symptoms much better.

0 general course 0 Resp / CVS 0 CPR 0 re-evaluation

consultation / review of records

_D/W Dr. _____
_D/W Dr.(#2) _____
_tried - can't contact Dr. ____
_family consultation _____
_old records ordered ____
_old records reviewed ____
_records req-unavailable ____
_further history sought ____

hospital admission or transfer

_admit _____
_transfer _____
_observation status _____
_good condition _____
_stable _____

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FIG. 34

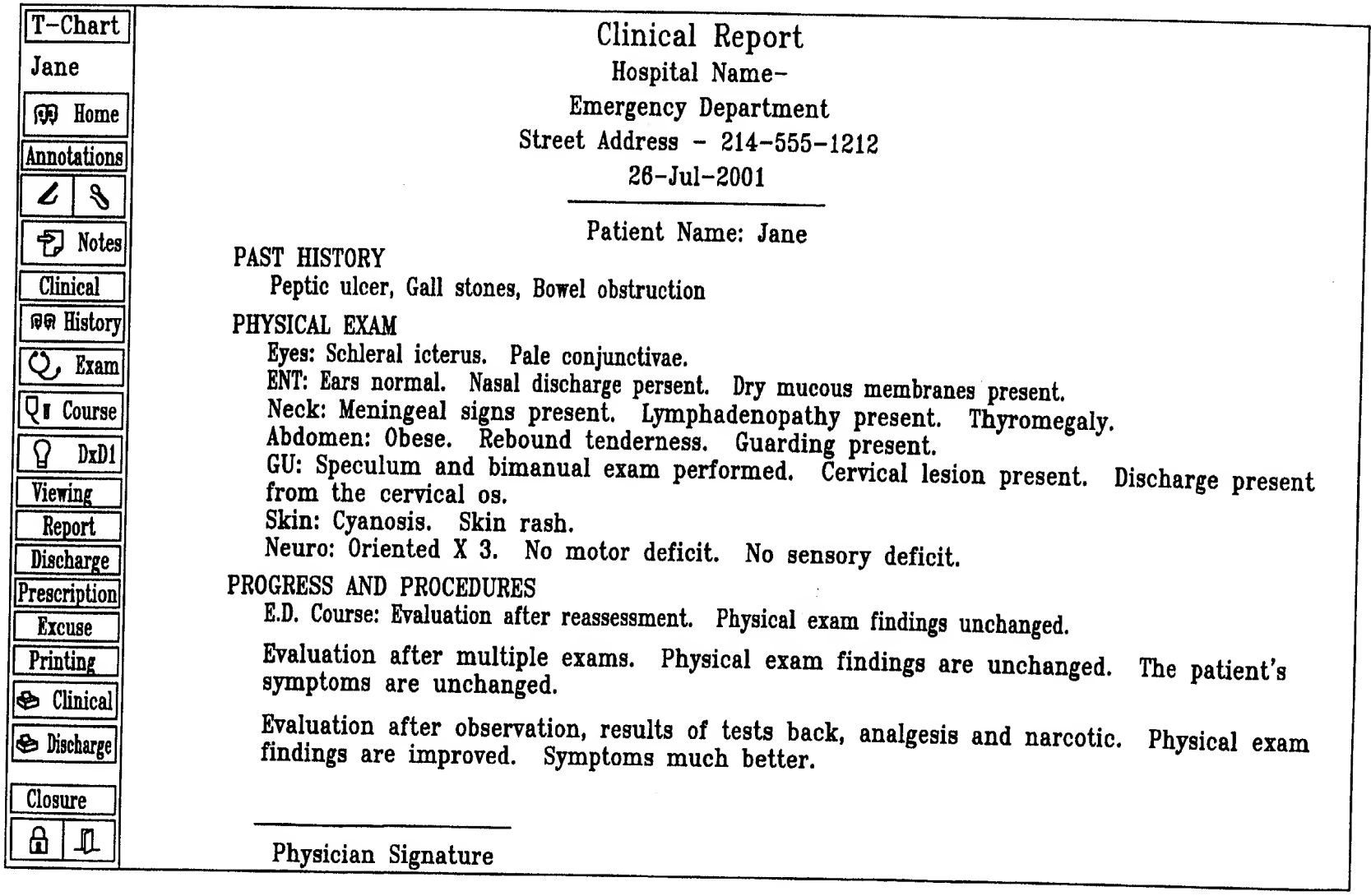
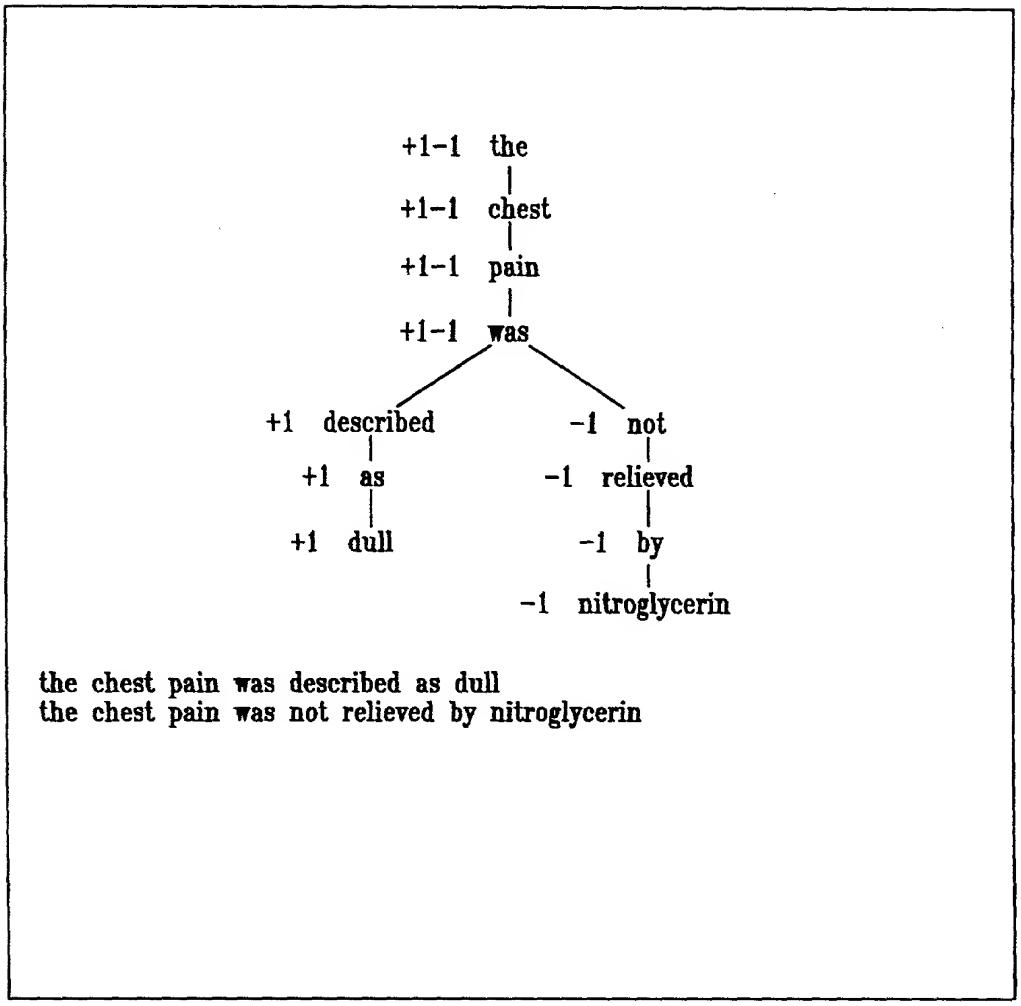
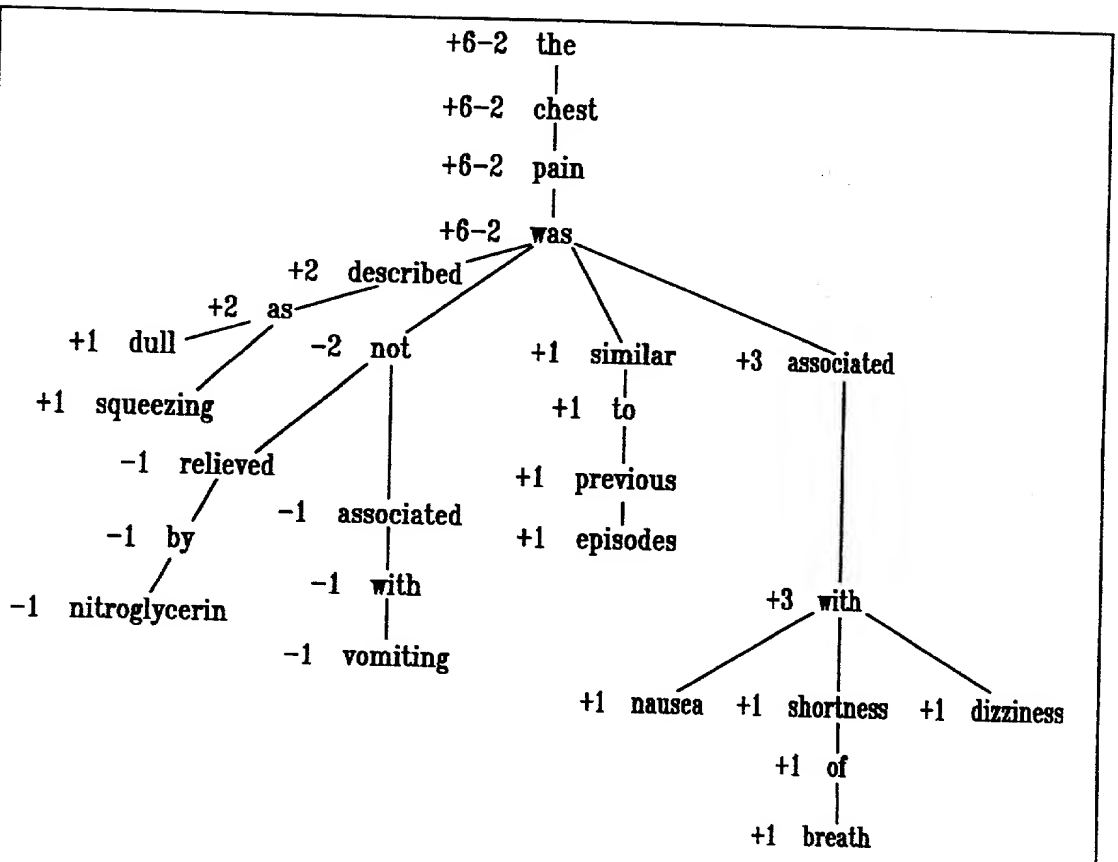


FIG. 35



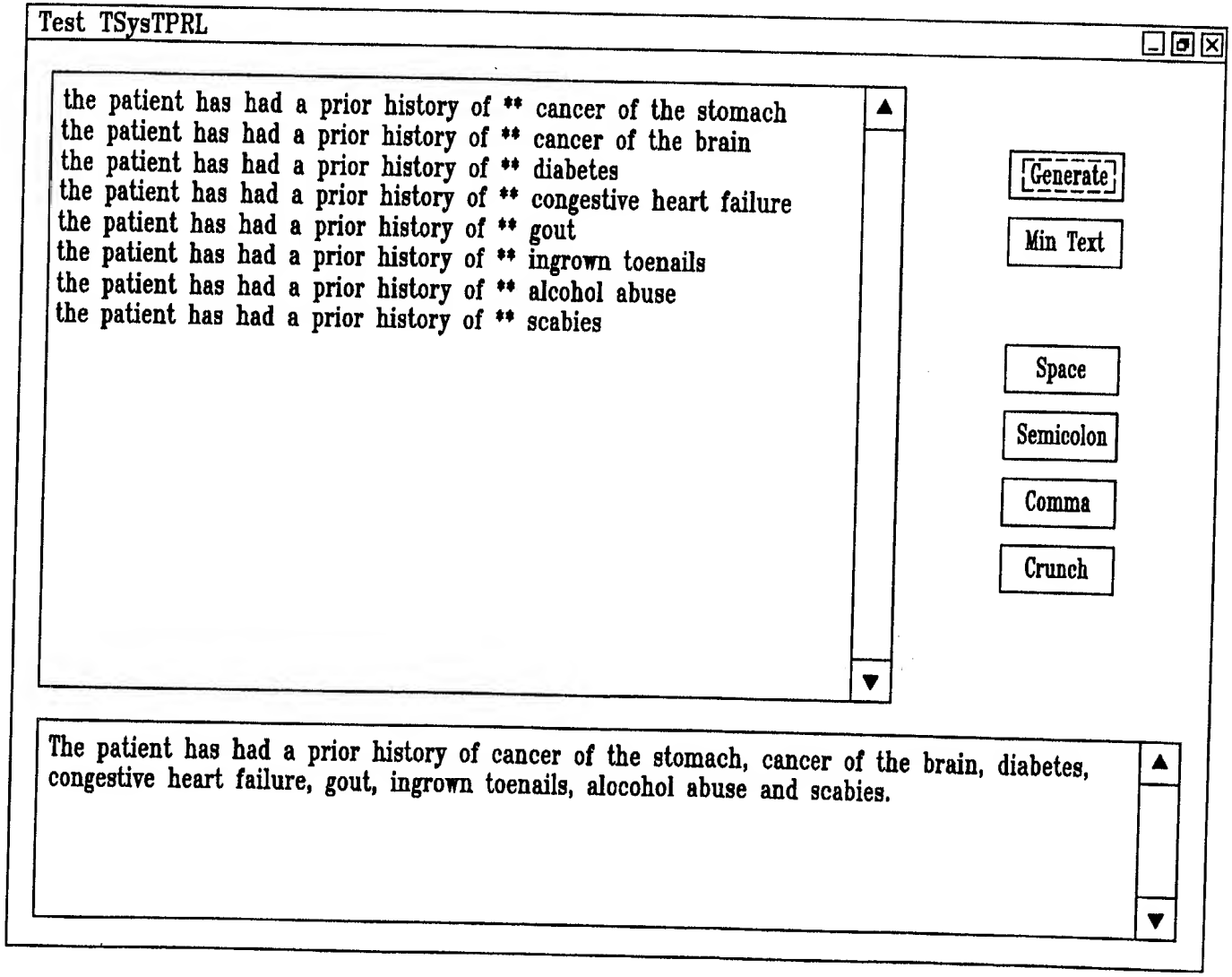
the chest pain was described as dull
the chest pain was not relieved by nitroglycerin

FIG. 36



the chest pain was described as dull
the chest pain was not relieved by nitroglycerin
the chest pain was similar to previous episodes
the chest pain was described as squeezing
the chest pain was associated with nausea
the chest pain was not associated with vomiting
the chest pain was associated with shortness of breath
the chest pain was associated with dizziness

FIG. 37


Test TSysTPRL
the patient has had a prior history of ** cancer of the stomach
the patient has had a prior history of ** cancer of the brain
the patient has had a prior history of ** diabetes
the patient has had a prior history of ** congestive heart failure
the patient has had a prior history of ** gout
the patient has had a prior history of ** ingrown toenails
the patient has had a prior history of ** alcohol abuse
the patient has had a prior history of ** scabies
Generate
Min Text
Space
Semicolon
Comma
Crunch
The patient has had a prior history of cancer of the stomach, cancer of the brain, diabetes, congestive heart failure, gout, ingrown toenails, alocohol abuse and scabies.